MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes O No	If yes _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes _____
Are you taking any medications, pills, or drugs?	O Yes O No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No	If yes _____
Are you on a special diet?	O Yes O No	
Do you use tobacco?	O Yes O No	
Do you use controlled substances?	O Yes O No	If yes _____

Women: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Renal Dialysis	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Rheumatic Fever	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatism	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Kidney Problems	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Liver Disease	O Yes O No	Swelling of Limbs	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tuberculosis	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pace Maker	O Yes O No	Radiation Treatments	O Yes O No	Yellow Jaundice	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Recent Weight Loss	O Yes O No		

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain _____

_____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN

_____ DATE_____

MEDICATION LIST

Name _____ Birth Date _____

Medications have an impact on the environment of the mouth. To help Dr. Blake perform safe dentistry and help you achieve optimal oral care, please list ALL medications and supplements you are taking.

This includes

- prescription drugs
- over-the-counter medications
- herbal supplements
- vitamins
- minerals

Substances may be administered

- by mouth
- via suppository
- as a patch

It is especially important to list aspirin, blood thinners, and medications to treat osteoporosis.

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If you already maintain a list of all medications and supplements, please attach your prepared copy.