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MEDICAL HISTORY

PATIENT NAME____ Birth date______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is an integral 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? θYes θ No If yes, Physician's name:______________________
Have you ever been hospitalized or had a major operation? θYes θ No If yes, describe:______________________
Have you ever had a serious head or neck injury? θYes θ No If yes, please explain:______________________
Are you taking any medications, pills or drugs? θYes θ No If yes, please list:______________________
Do you take, or have you taken, Phen-Fen or Redux? θYes θ No ______________________
Are you on a special diet? θYes θ No If yes, type of diet:______________________
Do you use tobacco of any kind? θYes θ No If yes, θ Smoke θ Chew Tobacco θ Snuff
Do you use controlled substances? θYes θ No If yes, name of substance:______________________

Women: Are you

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

Pre-Meds

Taking an antibiotic pre-med? θYes θNo Med____________

Are you allergic to any of the following?

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

θ Other If yes, please explain:

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

θ AIDS/HIV Positive	θ Chest Pains	θ Frequent Headaches	θ Irregular Heartbeat	θ Scarlet Fever
θ Alzheimer's Disease	θ Cold Sores/Fever Blisters	θ Genital Herpes	θ Kidney Problems	θ Shingles
θ Anaphylaxis	θ Congenital Heart Disorder	θ Glaucoma	θ Leukemia	θ Sickle Cell Disease
θ Anemia	θ Convulsions	θ Hay Fever	θ Liver Disease	θ Sinus Trouble
θ Angina	θ Cortisone Medicine	θ Heart Attack/Failure	θ Low Blood Pressure	θ Spina Bifida
θ Arthritis/Gout	θ Diabetes	θ Heart Murmur	θ Lung Disease	θ Stomach/Intestinal Disease
θ Artificial Heart Valve	θ Drug Addiction	θ Heart Pace Maker	θ Mitral Valve Prolapse	θ Stroke
θ Artificial Joint	θ Easily Winded	θ Heart Trouble/Disease	θ Pain in the Jaw Joints	θ Swelling of the Limbs
θ Asthma	θ Emphysema	θ Hemophilia	θ Parathyroid Disease	θ Thyroid Disease
θ Blood Disease	θ Epilepsy or Seizures	θ Hepatitis A	θ Psychiatric Care	θ Tonsillitis
θ Blood Transfusion	θ Excessive Bleeding	θ Hepatitis __ B or __ C	θ Radiation Treatments	θ Tuberculosis
θ Breathing Problem	θ Excessive Thirst	θ Herpes	θ Recent Weight Loss	θ Tumors or Growths
θ Bruise Easily	θ Fainting Spells/Dizziness	θ High Blood Pressure	θ Renal Dialysis	θ Ulcers
θ Cancer	θ Frequent Cough	θ Hives or Rash	θ Rheumatic Fever	θ Venereal Disease
θ Chemotherapy	θ Frequent Diarrhea	θ Hypoglycemia	θ Rheumatism	θ Yellow Jaundice

Diagnosed with *osteoperosis* or *metastatic bone cancer*? θ Yes θ No. Are you now or have you ever taken **Bisphosphonate** medications such as Didronel(Orally), Skelid(Orally), Fosamax(Orally), Actonel(Orally), Boniva(Orally), Aredia(IV) or Zometa(IV)? θ Yes θ No. If so, for how long? _____ θ days, θ months, θ years and at what dosage (if known)? _____ mg θ 1X, θ 2X, θ 3X, θ 4X……θ daily or θ weekly.

Have you ever had any serious illness not listed above? θ Yes θ No If yes, please explain:______________________

Acknowledgement and Consent

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 this dental office of any changes in my (patient's) medical status.

My signature below acknowledges my receipt of the brochures entitled "*Our Office*" (Form OO, Edition Date 7/1/2012), "*Financial Policies*" (Form FP, Edition Date 7/1/2012), "*Notice of Privacy Practices"* (Form PP, Edition Date 7/1/2012), *"Bisphosphonate Induced Osteonecrosis of the Jaws" if applicable* (Form BP, Edition Date 7/1/2012), *"Informed Consent for Dental Treatment"*, (Form IC, Edition Date 7/1/2012) and that I have had full opportunity to read, understand and consider the contents and implications of the information provided in these brochures. I understand that by signing this form, I agree to abide by the published financial policies of this office and hereby give my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as described in the *"Notice of Privacy Practices"* brochure. In addition, I read, write and communicate in the English language.

My initials in the space that follows also gives my consent for this office to bill my insurance for services rendered with benefits made payable to this office. We will keep this signature on file for future insurance claims. Initials:________

Signed:____ Date:______________________________

Patient, Parent or Legal Guardian (Must be 18 years or older)