Caring Smile Family Dentistry Medical History

Patient Name: _____ Date Created: _____

Although dental personnel primarily treat the area 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? YES / NO
If yes Name of physician and date of last exam: _____

Have you ever been hospitalized or had a major operation? YES / NO
If yes, please explain: _____

Have you ever had a serious head or neck injury? YES / NO
If yes, please explain: _____

Are you taking any medications, pills, or drugs? YES / NO
Please individually list all including OTC and supplements or attach a list: _____

_____

Do you take blood thinners or Aspirin? YES/ NO
If yes, please list: _____

Do you, or have you taken Phen-Fen or Redux? YES / NO
If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphates? YES / NO
If yes, please explain: _____

Do you have dietary restrictions? YES / NO
If yes, please explain: _____

Do you use, or have you ever used tobacco? YES / NO
If yes, please explain: _____

Do you use any controlled substances, prescription or non- prescription? YES / NO
If yes, please list: _____

Women Are You: ___ Pregnant ___Nursing ___ Taking oral contraceptives ___ None of the above

Are you allergic to any of the following: ___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex

___Sulfa Drugs ___Local Anesthetics ___Other ___No Known Allergies

If Other, please list: _____

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Do you have, or have you had any of the following? Please circle Y(yes) or N (no)

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

Have you ever had any serious illness not listed above? Y / N If Yes: _____

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 or Guardian:

X_____ Date: _____