Signature of Patient, Parent or Guardian:

X

Man gum Family Dentistry

Medical History

Patient Name: Birth Date: Date Created:

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. Yes No Are you under a physician's care now? If yes Have you ever been hospitalized or had a major Yes No If yes oneration? Have you ever had a serious head or neck injury? Yes No If yes Are you taking any medications, pills, or drugs? Yes No If yes Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes Have you ever taken Fosamax, Boniva, Actonel or Yes No If yes any other medications containing bisphosphonates? Are you on a special diet? Yes No Do you use tobacco? Yes No Women: Are you... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic A Metal Latex Sulfa Drugs Local Anesthetics Other? If yes Do you use controlled substances? Yes No If yes Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No Alzheimer's Disease Yes No Diahetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Yes No Drug Addiction Yes No Yes No Renal Dialysis Yes No Anaphylaxis Hepatitis B or C Yes No Yes No Yes No Yes No Anemia Easily Winded Herpes Rheumatic Fever Yes No Yes No Yes No Yes No Angina Emphysema High Blood Pressure Rheumatism Yes No Yes No Yes No Yes No Scarlet Fever Arthritis/Gout Epilepsy or Seizures High Cholesterol Yes No Yes No Yes No Yes No Artificial Heart Valve Excessive Bleeding Hives or Rash Shingles Yes No Yes No Yes No Yes No Artificial Joint Excessive Thirst Hypoglycemia Sickle Cell Disease Yes No Fainting Spells/Dizziness Yes No Yes No Yes
No Acthma Irregular Heartbeat Sinus Trouble Yes No Yes No Yes No Yes No **Blood Disease** Frequent Cough Kidney Problems Spina Bifida Yes No Yes No Yes No Stomach/Intestinal Disease Yes No Blood Transfusion Frequent Diarrhea Leukemia Yes No Yes No Yes
No Yes No **Breathing Problems** Frequent Headaches Liver Disease Stroke Yes No Yes No Yes No Bruise Easily Genital Herpes Low Blood Pressure Swelling of Limbs Yes No Yes No Yes No Yes No Yes No Cancer Glaucoma Lung Disease Thyroid Disease Yes No Yes No Yes No Tonsillitis Yes No Mitral Valve Prolapse Chemotherapy Hay Fever Yes No Yes No Yes No Chest Pains Yes No Heart Attack/Failure Osteoporosis Tuberculosis Cold Sores/Fever Blisters @ Yes @ No Yes No Yes No Yes No Heart Murmur Pain in Jaw Joints Tumors or Growths Congenital Heart Disorder Pes No Yes No Yes No Yes No Heart Pacemaker Parathyroid Disease Ulcers Heart Trouble/Disease Pes No Yes No Yes No Yes No Convulsions Psychiatric Care Venereal Disease Yellow Jaundice Yes No Have you ever had any serious illness not listed Yes No 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.