

Medical History for: (First Name) \_\_\_\_\_ (Last Name) \_\_\_\_\_

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please look over the following questions carefully and thank you for answering completely and accurately. We look forward to your visit!

Are you under a physicians care now?  Yes  No If yes, please explain \_\_\_\_\_

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 If yes, please fill in here: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_

Are you on a special diet?  Yes  No \_\_\_\_\_

Do you use tobacco products?  Yes  No What? \_\_\_\_\_ How much/day? \_\_\_\_\_

Do you use controlled substances?  Yes  No What? \_\_\_\_\_

**Women**, are you: Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metals  Latex  Local Anesthetic

Are you allergic to anything else?  Yes  No Please explain \_\_\_\_\_

**Please check (✓) if you have, or have ever had, any of the following?**

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

Have you had any serious illness not listed above?  If yes, please explain \_\_\_\_\_

Are you now taking, or have you ever taken, prescribed medications called bisphosphonates?  Yes  No

Do you have Pagets Disease of the bone?  Yes  No

Have you ever had Muptiple Myeloma?  Yes  No

Have you ever had any malignancy of the bones?  Yes  No

Do you have osteoporosis?  Yes  No

Thank you for answering this form accurately and to the best of your knowledge. Please understand that providing incorrect information could be dangerous to your health. It is your responsibility to inform Grove Health Dental of any changes in your medical status.