New Medical History Form.

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? *

○ Yes ○ No

Have you ever been hospitalized or had a major operation? *

○ Yes ○ No

Have you ever had a serious head or neck injury? *

○ Yes ○ No

Are you taking any medications, pills, or drugs? *

○ Yes ○ No

Do you take, or have you taken, Phen-Fen or Redux? *

○ Yes ○ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? *

○ Yes ○ No

Are you on a special diet? *

○ Yes ○ No

Do you use tobacco? *

○ Yes ○ No

Do you use controlled substances? *

○ Yes ○ No

Women: Are you...

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

Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Other: ☐ Penicillin ☐ Sulfa Drugs

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

AIDS/HIV Positive *
○ Yes ○ No

Alzheimer's Disease *
○ Yes ○ No

Anaphylaxis *
○ Yes ○ No

Anemia *
○ Yes ○ No

Angina *
○ Yes ○ No

Arthritis/Gout *
○ Yes ○ No

Artificial Heart Valve *
○ Yes ○ No

Artificial Joint *
○ Yes ○ No

Asthma *
○ Yes ○ No

Blood Disease *
○ Yes ○ No

Blood Transfusion *
○ Yes ○ No

Breathing Problems *
○ Yes ○ No

Bruise Easily *
○ Yes ○ No

Cancer *
○ Yes ○ No

Chemotherapy *
○ Yes ○ No

Chest Pains *
○ Yes ○ No

Cold Sores/Fever Blisters *
○ Yes ○ No

Congenital Heart Disorder *
○ Yes ○ No

Convulsions *
○ Yes ○ No

Cortisone Medicine *
○ Yes ○ No

Diabetes *
○ Yes ○ No

Drug Addiction *
○ Yes ○ No

Easily Winded *
○ Yes ○ No

Emphysema *
○ Yes ○ No

Epilepsy or Seizures *
○ Yes ○ No

Excessive Bleeding *
○ Yes ○ No

Excessive Thirst *
○ Yes ○ No

Fainting Spells/Dizziness *
○ Yes ○ No

Frequent Cough *
○ Yes ○ No

Frequent Diarrhea *
○ Yes ○ No

Frequent Headaches *
○ Yes ○ No

Genital Herpes *
○ Yes ○ No

Glaucoma *
○ Yes ○ No

Hay Fever *
○ Yes ○ No

Heart Attack/Failure *
○ Yes ○ No

Heart Murmur *
○ Yes ○ No

Heart Pacemaker *
○ Yes ○ No

Heart Trouble/Disease *
○ Yes ○ No

Hemophilia *
○ Yes ○ No

Hepatitis A *
○ Yes ○ No

Hepatitis B or C *
○ Yes ○ No

Herpes *
○ Yes ○ No

High Blood Pressure *
○ Yes ○ No

High Cholesterol *
○ Yes ○ No

Hives or Rash *
○ Yes ○ No

Hypoglycemia *
○ Yes ○ No

Irregular Heartbeat *
○ Yes ○ No

Kidney Problems *
○ Yes ○ No

Leukemia *
○ Yes ○ No

Liver Disease *
○ Yes ○ No

Low Blood Pressure *
○ Yes ○ No

Lung Disease *
○ Yes ○ No

Mitral Valve Prolapse *
○ Yes ○ No

Osteoporosis *
○ Yes ○ No

Pain in Jaw Joints *
○ Yes ○ No

Parathyroid Disease *
○ Yes ○ No

Psychiatric Care *
○ Yes ○ No

Radiation Treatments *
○ Yes ○ No

Recent Weight Loss *
○ Yes ○ No

Renal Dialysis *
○ Yes ○ No

Rheumatic Fever *
○ Yes ○ No

Rheumatism *
○ Yes ○ No

Scarlet Fever *
○ Yes ○ No

Shingles *
○ Yes ○ No

Sickle Cell Disease *
○ Yes ○ No

Sinus Trouble *
○ Yes ○ No

Spina Bifida *
○ Yes ○ No

Stomach/Intestinal Disease *
○ Yes ○ No

Stroke *
○ Yes ○ No

Swelling of Limbs *
○ Yes ○ No

Thyroid Disease *
○ Yes ○ No

Tonsillitis *
○ Yes ○ No

Tuberculosis *
○ Yes ○ No

Tumors or Growths *
○ Yes ○ No

Ulcers *
○ Yes ○ No

Venereal Disease *
○ Yes ○ No

Yellow Jaundice *
○ Yes ○ No

Have you ever had any serious illness not listed above? *
○ Yes ○ No

If Yes to any of the above, please explain:

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.

Sign Here

Signature *