Time 1:03 PM

Date 7/22/2019

Current Medical History 2019

Patient Name:

Birth Date:

Date Created:

General

This information is vital to allow us to provide appropriate care for you. We do not use this information to discriminate.

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Have you had an orthopedic total joint (hip,knee,elbow,finger(replacement?	◯ Yes ◯ No	If yes	
Are you taking any medications?	◯ Yes ◯ No	If yes	
Have you ever taken alendronate or risendronate (Fosomax/Actonel) for osteoporosis?	◯ Yes ◯ No	If yes	
Have you had intravenous bisphosphonates?	◯ Yes ◯ No		
Have you had previous infective endocardidis, damaged heart valve or artificial heart valve?	◯ Yes ◯ No		
Do you have congestive heart failure, cardiovascular disease or congenital heart disease?	◯ Yes ◯ No		
Do you have neurological, gastrointestinal or autoimmune disease?	◯ Yes ◯ No		
Are you pregnant or nursing?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Have you had any periodontal (gum) treatments?	◯ Yes ◯ No		
Do you drink bottled, filtered or tap water?	◯ Yes ◯ No		
Do you have pain, clicking or popping in jaw joints?	◯ Yes ◯ No		

Allergies

Are you allergic to the following?

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

General History

Have you been diagnosed or have signs of....

☐ ADD/ADHD	☐ Alzheimer's	☐ Anxiety	☐ Aspergers
☐ Autism	☐ Depression	☐ Dementia	☐ Excessive Worry
☐ OCD	☐ Sensory Disorder	☐ Other	

Medical History

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

Acid Reflux	◯ Yes ◯ No	AIDS/HIV Positive	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Bleeding Disorder	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Chronic Pain	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No
Cortisone Medication	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Eating Disorder	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Glaucoma	◯ 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
Mitro Valve Prolapse	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Recent Weight Loss	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Sleep Disorder	◯ Yes ◯ No	STD	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Ulcers	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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 my medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____