MEDICAL HISTORY

Patient Name: _____ **Birth 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.

Are you under a physician's care now, and who?	○ Yes → Please explain: ○ No	
Have you ever been hospitalized or had a major operation?	○ Yes → Please explain: ○ No	
Have you ever had a serious head or neck injury?	○ Yes → Please explain: ○ No	
Have you or do you take Phen-Fen, Redux, Fosamax, Boniva, Actonel or any other bisphosphonates?	○ Yes → Please explain: ○ No	
Do you use any form of tobacco or marijuana? How often?	○ Yes → Please explain: ○ No	
Do you use controlled substances that are not prescribed?	○ Yes → Please explain: ○ No	
Do you or someone in your house snore?	○ Yes → Please explain: ○ No	
Do you or someone in your house have sleep apnea?	○ Yes → Please explain: ○ No	
Have you ever had a sleep test and how long ago?	○ Yes → Please explain: ○ No	
Are you interested in improving the look of your teeth?	○ Yes → Please explain: ○ No	
Are you interested in straightening your teeth?	○ Yes → Please explain: ○ No	

Women: are you...

- ☐ Pregnant
- ☐ Nursing
- ☐ Trying to become pregnant
- ☐ Taking oral contraceptives

Are you allergic to any of the following?

- ☐ No Known Allergies
- ☐ Iodine
- ☐ Local anesthetics
- ☐ Latex
- ☐ Plastics
- ☐ Metals
- ☐ Aspirin
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Antibiotics
- ☐ Penicillin
- ☐ Other:

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

- ☐ Alzheimer's
- ☐ Parkinson's Disease
- ☐ Epilepsy or Seizures
- ☐ Multiple Sclerosis
- ☐ Glaucoma
- ☐ Mood Disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Chronic Pain
- ☐ Neuralgia
- ☐ Fibromyalgia
- ☐ Chronic Headaches
- ☐ Sinus Problems
- ☐ Pain in Jaw Joints
- ☐ Chronic Ear Pain
- ☐ Chronic Ear Infections
- ☐ Tinnitus
- ☐ Meniere's Disease
- ☐ Fainting Spells/Dizziness
- ☐ Heart Trouble/Disease
- ☐ Stroke
- ☐ Heart Attack/Failure
- ☐ Angina/Chest Pains
- ☐ Blood Pressure (High)
- ☐ Blood Pressure (Low)
- ☐ Metabolic Syndrome
- ☐ Coronary Heart Disease
- ☐ Atherosclerosis
- ☐ Endocarditis
- ☐ Congenital Heart Disease
- ☐ Heart Valve Replacement
- ☐ Heart Pacemaker
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Atrial Fibrillation
- ☐ Atrioventricular Block
- ☐ Blood Disease
- ☐ Hemophilia
- ☐ Bleed/Bruise Easily
- ☐ Anemia
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ COPD
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ Tumors or Growths
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Immune System Disorder
- ☐ AIDS/HIV Positive
- ☐ Acid Reflux
- ☐ Liver Disease
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Drug Addiction
- ☐ Orthodontic Treatment
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Arthritis/Gout
- ☐ Artificial Joint
- ☐ Cortisone Medication
- ☐ Rheumatoid Arthritis
- ☐ Anaphylaxis
- ☐ Rheumatic Fever
- ☐ Muscular Dystrophy
- ☐ Kidney Problems
- ☐ Urinary Disorder
- ☐ Chronic Fatigue
- ☐ Insomnia
- ☐ Daytime Sleepiness
- ☐ Difficulty Sleeping
- ☐ Sleep Apnea

Please List All Medications and Reason for Use:

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, Parent or Guardian: _____ **Date:** _____

Dr's Signature/Medical History Review: _____ **Date:** _____