Stone Creek
DENTAL CARE

MEDICAL HISTORY

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

Who is your primary physician? _____
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 explain_____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Have you ever taken Fosamax, Boniva, Actonel or 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

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs
Other If yes, please explain_____

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

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 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 Pace Maker
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
Or "Thin bones"
yes no Pain in Jaw Joints
yes no Parathyroid Disease
yes no Psychiatric Disease
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

Have you ever had any serious illness not listed above? Yes No If yes, please explain_____

Presently being treated for any illness? Yes No
Considered a touchy person? Yes No
Easily upset or irritated? Yes No
Often unhappy or depressed? Yes No

Women: Are you: Pregnant? Trying to get pregnant? Nursing? Taking oral contraceptives?

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_____

SIGNATURE OF DOCTOR _____DATE_____