Hometown Dental Clinic
Medical History

Today's date: _____

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?	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_____
Are you taking any medications, pills, or drugs?	Yes	No	If yes_____ _____
Do you require Premedication (Antibiotics) prior to your dental appointment?	Yes	No	If yes_____
Have you ever taken Fosamax, Boniva Actonel, or any other bisphosphonates?	Yes	No	If yes_____
Do you use controlled substances?	Yes	No	If yes_____
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	

For women: Are you…

Pregnant/trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa drugs	Local Anesthetics

Other_____

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

AIDS/HIV Positive	Yes	No	Frequent Cough	Yes	No	Osteoporosis	Yes	No
Alzheimer's Disease	Yes	No	Frequent Diarrhea	Yes	No	Pain in Jaw Joints	Yes	No
Anaphylaxis	Yes	No	Frequent Headaches	Yes	No	Parathyroid Disease	Yes	No
Anemia	Yes	No	Genital Herpes	Yes	No	Psychiatric Care	Yes	No
Angina	Yes	No	Glaucoma	Yes	No	Radiation Treatments	Yes	No
Arthritis/Gout	Yes	No	Hay Fever	Yes	No	Recent Weight Loss	Yes	No
Artificial Heart Valve	Yes	No	Heart Attack/Failure	Yes	No	Renal Dialysis	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Rheumatic Fever	Yes	No
Blood Disease	Yes	No	Heart Pacemaker	Yes	No	Rheumatism	Yes	No
Blood Transfusion	Yes	No	Heart Trouble/Disease	Yes	No	Scarlet Fever	Yes	No
Breathing Problems	Yes	No	Hemophilia	Yes	No	Shingles	Yes	No
Bruise Easily	Yes	No	Hepatitis A	Yes	No	Sickle Cell Anemia	Yes	No
Cancer	Yes	No	Hepatitis B or C	Yes	No	Sinus Trouble	Yes	No
Chemotherapy	Yes	No	Herpes	Yes	No	Spina Bifida	Yes	No
Chest Pains	Yes	No	High Blood Pressure	Yes	No	Stomach Problems	Yes	No
Cold Sores/Fever Blisters	Yes	No	High Cholesterol	Yes	No	Stroke	Yes	No
Congenital Heart Disease	Yes	No	Hives or Rash	Yes	No	Swelling of limbs	Yes	No
Convulsions	Yes	No	Hypoglycemia	Yes	No	Thyroid Disease	Yes	No
Cortisone Medicine	Yes	No	Irregular Heartbeat	Yes	No	Tonsilitis	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Tuberculosis	Yes	No
Drug Addiction	Yes	No	Leukemia	Yes	No	Tumors or Growths	Yes	No
Easily Winded	Yes	No	Liver Disease	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Low Blood Pressure	Yes	No	Venereal Disease	Yes	No
Epilepsy or Seizures	Yes	No	Lung Disease	Yes	No	Yellow Jaundice	Yes	No
Excessive Bleeding	Yes	No	Mitral Valve Prolapse	Yes	No			
Fainting Spells/Dizziness	Yes	No						

Have you ever had any serious illness not listed above?

Yes No If yes_____

Comments:

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:

X_____ Date: _____