Patient 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.

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: ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes: ______________________

Do you use tobacco? Yes No If yes: ______________________

Do you use controlled substances? Yes No If yes: ______________________

Women: Are you... Pregnant or Trying to get pregnant? Due date: ________ Nursing? Taking Oral Contraceptives?

Are you alergic to any of the following?

Aspirin	Penicilin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Do you have any Allergies not listed above? Yes No If yes: ______________________

AIDS/HIV Positive	Disabled	Heart Trouble/Disease	Renal Disease
Alzheimer's Disease	Dizziness/Vertigo	Hepatitis A	Rheumatic Fever
Anaphylaxis	Down Syndrome	Hepatitis B	Rheumatism
Anemia	Drug Addiction	Hepatitis C	Scarlet Fever
Arthritis/Gout	Easily Winded	Herpes	Sexually Trasmitted Disease
Artificial Heart Valve	Emphysema	High Blood Pressure	Shingles
Artificial Joint	Epilepsy or Seizures	High Cholesterol	Sickle Cell Disease
Asthma	Excessive Bleeding	Hives or Rash	Sinus Trouble
Blood Disease	Excessive Thirst	Hypoglycemia	Spina Bifida
Blood Thinning Medication	Fainting Spells	Irregular Heartbeat	Stomach/Intestinal Disease
Blood Transfusion	Frequent Cough	Kidney Problems	Stroke
Bruise Easily	Frequent Diarrhea	Leukemia	Swelling of Limbs
Cancer	Frequent Headaches	Liver Disease	Thyroid Disease
Chemotherapy/Radiation	Gags Easily	Low Blood Pressure	Tonsillitis
Chest Pains	Glaucoma	Lung Disease	Tuberculosis
Cold Sores	Handicapped	Mitral Valve Prolapse	Tumors
Congenital Heart Disorder	Hay Fever	Osteoporoses	Ulcers
Convulsions	Hearing Impaired	Pain in Jaw Joints	Vision Impaired
Cortisone Medication	Heat Attack/Failure	Parathyroid Disease	Wheelchair Bound
Diabetes	Heart Pace Maker	Psychiatric Care	Yellow Jaundice

Have you had any serious illnesses not listed above? Yes No If yes: ______________________

Do you have an artificial joint? If yes, please note which joint and date of replacement. Yes No If yes: ______________________

Additional 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 / Guardian: ______________________ Date: ____/____/____

WINTERHOLLER
Dentistry & Implant Surgery