

# Shady Cove Family Dentistry

## Medical History Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

*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.*

	Yes	No	If yes
<b>Do you have a primary care provider?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Have you ever been hospitalized or had a major operation?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Have you ever had a serious head or neck injury?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Are you taking any medications, pills, or drugs?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Do you take, or have you taken, Phen-Fen or Redux?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Have you ever taken Fosamax, Boniva, Actonel or another other medication containing bisphosphonates?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Are you on a special diet?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Do you use tobacco?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Do you use controlled substances?</b>	<input type="checkbox"/>	<input type="checkbox"/>	

Women: Are you...		
<input type="checkbox"/> Pregnant/Trying to get pregnant?	<input type="checkbox"/> Nursing?	<input type="checkbox"/> Taking oral contraceptives?

Are you allergic to any of the following?				
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic	
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics	
<input type="checkbox"/> Other?				

Do you have, or have you had, any of the following? Check box if applies			
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Radiation Treatments
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes: Type_____	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Renal Dialysis

<input type="checkbox"/> Anemia	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hives/Rash	<input type="checkbox"/> Shingles
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Frequent Headache	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mitral Valve Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Tumors/Growths
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Venereal Disease
			<input type="checkbox"/> Yellow Jaunice
Have you ever had any serious illness not listed above? If yes, please list: _____			

Comments:
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<u>X</u> _____	
<i>Signature of Patient, Parent or Guardian</i>	<i>Date</i>