MAIN STREET DENTAL

PATIENT MEDICAL HISTORY

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 take or have you taken , Phen-Fen or Redux? Yes ☐ No ☐ If Yes: _____

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

Are you on a special diet? Yes ☐ No ☐ If Yes: _____

Do you use tobacco? Yes ☐ No ☐ If Yes: _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If Yes: _____

Do you use controlled substances? Yes ☐ No ☐ If Yes: _____

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

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

Have you ever had any serious illness not listed Yes ☐ No ☐ If Yes: _____

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 responsitility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X _____ Date: _____