STEPHANIE WARDEN DDS

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MEDICAL HISTORY

PATIENT NAME	BIRTH DATE	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 ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other __________

If yes, please explain:

Question	Answer	
Are you under a physician's care now?	☐ Yes ☐ No	If Yes, please explain
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 prescription medication, pills or drugs?	☐ Yes ☐ No	If Yes, please explain
Are you taking any non prescription medication, pills or drugs?	☐ Yes ☐ No	If Yes, please explain
Do you take, or have you taken: Phen-Fen or Redux?	☐ Yes ☐ No	If Yes, please explain
Do you take or have you taken: Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If Yes, please explain
Are you on a special diet?	☐ Yes ☐ No	If Yes, please explain
Do you use tobacco?	☐ Yes ☐ No	If Yes, how much?
Do you drink alcohol?	☐ Yes ☐ No	If Yes, how much?
Women: Are you pregnant/trying to get pregnant?	☐ Yes ☐ No	If Yes, please explain
Are you nursing?	☐ Yes ☐ No	If Yes, please explain
Are you taking oral contraceptives?	☐ Yes ☐ No	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

☐ Acid Reflux/Persistent Heart Burn	☐ Drug Dependancy	☐ Heart Attack/Failure	☐ Pain in Jaw Joints
☐ AIDS/HIV Positive	☐ Chemotherapy	☐ Heart Pacemaker	☐ Psychiatric Care
☐ Anaphylaxis	☐ Circulatory Problems	☐ Heart Problem/Disorder	☐ Radiation Treatments
☐ Arthritis/Rheumatism	☐ Cold Sores/Fever Blisters	☐ Hepatitis	☐ Sinus Trouble
☐ Artificial Valve	☐ Congenital Heart Disorder/Defect	☐ High or Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Artificial Joint	☐ Cortisone Treatments	☐ History of Bacterial Endocarditis	☐ Stroke
☐ Asthma/Breathing Problems	☐ Diabetes Type I or II	☐ HPV (Human Papilloma Virus)	☐ Systemic Lupus Erythematous
☐ Autoimmune Disease	☐ Dry Mouth	☐ Kidney Problems	☐ Thyroid Disease
☐ Back or Neck Problems	☐ Eating Disorder	☐ Liver Disease	☐ Tonsilitis
☐ Bleeding Disorders/Anemia	☐ Epilepsy/Seizure Disorder	☐ Lung Disease	
☐ Cancer	☐ Frequent Headaches	☐ Osteoporosis/Osteopenia	

Have you ever had any serious illness not listed above? Yes No (If yes, please explain) __________

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

____
DATE

Reset/Clear Form