HUNTLEY DENTAL ASSOCIATES

# Medical History Form

Patient Name: Birth Date: Date Created:

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 dental treatment. Thank you.

| | | |
|---|---|---|
| Are you under a physician's care now other than routine regular check ups? | ○ 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 controlled substances? | ○ Yes ○ No | If yes |
| Do you use tobacco? | ○ Yes ○ No | |

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Penicillin | ☐ Codeine | ☐ Metal |
| ☐ Latex | ☐ Sulfa Drugs | ☐ Local Anesthetics | |

Other? ☐ If yes

WOMEN ONLY: Are you...

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

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

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Alzheimer's | ☐ Anemia | ☐ Angina |
| ☐ Arthritis | ☐ Artificial Heart Valve | ☐ Arificial Joint | ☐ Asthma |
| ☐ Blood Disease | ☐ Blood Transfusion | ☐ Cancer (list type below) | ☐ Chemotherapy |
| ☐ Chest Pains | ☐ Cold Sores/Fever Blisters | ☐ COPD | ☐ Cortisone Medicine |
| ☐ Dementia | ☐ Diabetes Type I | ☐ Diabetes Type II | ☐ Drug Addiction |
| ☐ Emphysema | ☐ Excessive Bleeding | ☐ Excessive Thirst | ☐ Fainting Spells/Dizziness |
| ☐ Frequent Cough | ☐ Frequent Headaches | ☐ Genital Herpes | ☐ Glaucoma |
| ☐ Gout | ☐ Hearing Impairment | ☐ Heart Attack/Failure | ☐ Heart Murmur |
| ☐ Heart Pacemaker | ☐ Heart Trouble/Disease | ☐ Heart Disorder/Congenital | ☐ Hemophilia |
| ☐ Hepatitis A | ☐ Hepatitis B or C | ☐ Herpes | ☐ High Blood Pressure |
| ☐ High Cholesterol | ☐ Hypoglycemia | ☐ Irregular Heartbeat | ☐ Kidney Trouble/Disease |
| ☐ Leukemia | ☐ Liver Disease | ☐ Low Blood Pressure | ☐ Lung Disease |
| ☐ Mitral Valve Prolapse | ☐ Osteoporosis | ☐ Pain in Jaw Joints | ☐ Parathyroid Disease |
| ☐ Parkinson's | ☐ Psychiatric Care | ☐ Radiation Treatment | ☐ Recent Weight Loss |
| ☐ Renal Dialysis | ☐ Rheumatic Fever | ☐ Rheumatism | ☐ Scarlet Fever |
| ☐ Shingles | ☐ Sinus Trouble | ☐ Spina Bifida | ☐ Stomach/Intestinal Disease |
| ☐ Stroke | ☐ Thyroid Disease | ☐ Tuberculosis | ☐ Tumors or Growths |
| ☐ Ulcers | ☐ Venereal Disease | ☐ Yellow Jaundice | |

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

Change of Address: Y N Change of Insurance: Y N Home Phone: Cell Phone:

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:_____