gledhill dental

family & cosmetic dentistry

Patient Medical History Form

Patient Name:	DOB:	Today's Date:

Although dental personnel primarily treat the are 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 receive. Thank you for answering the following questions:

Are you under a physician's care now?	☐ Yes	☐ No	If yes:
Have you even 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? Do you use alcohol?	☐ Yes ☐ Yes	☐ No ☐ No	If yes: If yes:

Current weight: _____

Women: Are you: ☐ Pregnant ☐ Nursing ☐Taking oral contraceptives: _____

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

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

☐ AIDS/HIV Positive	☐ Cortisone Meds	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting | Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack | Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores| Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsion	☐ Heart Trouble | Disease	☐ Psychiatric Care	☐ Venereal Disease
☐ Yellow Jaundice	☐ Other:	☐ Other:	☐ Other:

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.

Patient Signature: _____ **Date:** _____

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