CORNERSTONE
•DENTAL•

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.

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Patient Name: _____ **Birth Date:** _____

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 medications, 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: _____

Have you ever taken, Fosamax, Boniva, Actonel or any other medication 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, please explain: _____

Do you use controlled substances? ❍ Yes ❍ No If yes, please explain: _____

Women: Are You

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking Oral Contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Allergies:

Are you allergic to any of the following: ❍ Asprin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics ❍ Sulfa Drugs

❍ Other: _____ If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above: ❍ Yes ❍ No _____

Additional 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