NEW PATIENT MEDICAL HISTORY

PATIENT NAME: ______________________________ DATE OF BIRTH: __________________

Primary Physician's Name: ____

Physician's Address: ______________________________ Phone Number: ____________________

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.

What is your occupation? ____

IF YOU ANSWER "YES" TO THE FOLLOWING QUESTIONS, PLEASE EXPLAIN:

- Are you under a physician's care now? YES ____ NO ____ __________________
- Have you been hospitalized or had a major operation, in the past 5 years? YES ____ NO ____ __________________
- Have you ever had a serious head or neck injury? YES ____ NO ____ __________________
- Are you taking any medications, pills, or drugs? YES ____ NO ____ __________________ __________________
- Do you take, or have you taken, Phen-Fen or Redux? YES ____ NO ____ __________________
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES ____ NO ____ __________________
- Are you on a special diet? YES ____ NO ____ __________________
- Do you use tobacco? YES ____ NO ____ __________________
- Do you use controlled substances? YES ____ NO ____ __________________

WOMEN: Are you . . .

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

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

____ Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____ Metal

____ Latex ____ Sulfa Drugs ____ Local Anesthetics ____ Other ____________________

PLEASE CIRCLE "Y" FOR YES, OR "N" FOR NO:

AIDS/HIV Positive	Y N	Cortisone Medicine	Y N	Hemophilia	Y N	Radiation Treatments . . .	Y N
Alzheimer's Disease	Y N	Diabetes	Y N	Hepatitis A	Y N	Recent Weight Loss	Y N
Anaphylaxis	Y N	Drug Addiction	Y N	Hepatitis B or C . . .	Y N	Renal Dialysis	Y N
Anemia	Y N	Rheumatic Fever	Y N	Angina	Y N	Emphysema	Y N
High Blood Pressure . . .	Y N	Rheumatism	Y N	Arthritis/Gout	Y N	Epilepsy or Seizures	Y N
High Cholesterol	Y N	Scarlet Fever	Y N	Artificial Heart Valve	Y N	Excessive Bleeding	Y N

Condition	Y/N	Condition	Y/N	Condition	Y/N	Condition	Y/N
Hives or Rash	Y N	Shingles	Y N	Artificial Joint	Y N	Excessive Thirst	Y N
Hypoglycemia	Y N	Sickle Cell Disease	Y N	Asthma	Y N	Fainting Spells/Dizziness	Y N
Irregular Heartbeat	Y N	Sinus Trouble	Y N	Blood Disease	Y N	Frequent Cough	Y N
Kidney Problems	Y N	Blood Transfusion	Y N	Frequent Diarrhea	Y N	Leukemia	Y N
Stomach/Intestinal Disease	Y N	Frequent Headaches	Y N	Liver Disease	Y N	Stroke	Y N
Bruise Easily	Y N	Low Blood Pressure	Y N	Cancer	Y N	Glaucoma	Y N
Lung Disease	Y N	Thyroid Disease	Y N	Chemotherapy	Y N	Hay Fever	Y N
Mitral Valve Prolapse	Y N	Tonsillitis	Y N	Chest Pains	Y N	Heart Attack/Failure	Y N
Osteoporosis	Y N	Tuberculosis	Y N	Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N
Pain in Jaw Joints	Y N	Tumors or Growths	Y N	Congenital Heart Disorder	Y N	Heart Pacemaker	Y N
Parathyroid Disease	Y N	Ulcers	Y N	Convulsions	Y N	Heart Trouble/Disease	Y N
Psychiatric Care	Y N	Yellow Jaundice	Y N	Heart Surgery	Y N	Autoimmune Disorder	Y N
Eating Disorder/Malnutrition	Y N						

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN: ____________________

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HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? No _____ Yes _____ If Yes, ____________________

____

SLEEP RELATED QUESTIONS: (if "YES", please explain)

Question	Y/N	Explanation
When walking up stairs or taking a walk, do you ever have to stop due to chest pain or shortness of breath?	Y N	________
Do your ankles ever swell during the day?	Y N	________
Do you use more than two pillows to sleep?	Y N	________
Do you, or have you ever been told, you snore?	Y N	________
Do you, or have you ever been told, you stop breathing during sleep?	Y N	________
Do you ever wake from sleep and feel a shortness of breath?	Y N	________
Have you lost or gained more than ten pounds in the past year?	Y N	________

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.

Signature of Patient, Parent or Guardian: ____________________

Doctor's Signature ____________________

Today's Date: ____________________