MEDICAL HISTORY

Address: 155 Smith Way, Suite 102 Soldotna, AK 99669 | **Phone:** (907) 262-4989 | **FAX:** 907-206-7892

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 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 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, 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

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex
☐ 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
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No

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Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Hepatitis A	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Mitral Valve prolapse	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Pain in Jaw joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Have you ever had any serious illness not listed above?	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

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**	