North Branch Dental

2015 Medical History Final

Patient Name: Birth Date:

Are you under a physician's care now?	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, supplements, or over-the-counter medications?	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 bisphosphonatese?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you use tobacco?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes

Women: Are you...

Pregnant	Yes No	Nursing	Yes No	Taking oral contraceptives	Yes No

Are you allergic to any of the following?

Aspirin	Yes No	Penicillin	Yes No	Amoxicillin	Yes No
Codeine	Yes No	Latex	Yes No	Sulfa Drugs	Yes No
Local Anesthetics	Yes No	Other	Yes No		

Medical Conditions

Please mark if you have or have had any of the following conditions:

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

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 the patient's) health. It is my responsibilty to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____