Five Star Dentists

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that 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 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? ◯Yes ◯No Taking oral contraceptives? ◯Yes ◯No Nursing? ◯Yes ◯No

Are you allergic to any of the following?

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

Have you ever had any serious illness not listed above? ◯Yes ◯No _____

Comments: _____

To the best of my knowledge, the question on this form 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 _____