PIKE LAKE DENTAL MEDICAL HISTORY FORM

PATIENT NAME ______________________ BIRTH DATE __________ 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 you may have, or medications that you may take, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

DO YOU HAVE A PRIMARY CARE PHYSICIAN? ☐ YES ☐ NO
IF YES, WHO AND WHERE? ______________________

DO YOU HAVE A PREFERRED PHARMACY? ☐ YES ☐ NO
F YES, WHAT IS IT? ______________________

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ______________________

HAVE YOU 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 LIST ______________________

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR
ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES? ☐ YES ☐ NO
IF YES, WHEN? ______________________

ARE YOU CURRENTLY TAKING A BLOOD THINNING MEDICATION? ☐ YES ☐ NO
IF YES, WHAT? ______________________

DO YOU USE TOBACCO? ☐ YES ☐ NO
IF YES, WHAT AND HOW OFTEN? ______________________

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

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DENTAL CENTER

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DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Condition			Condition		
AIDS/HIV POSITIVE	☐ YES	☐ NO	BLOOD TRANSFUSION	☐ YES	☐ NO
ALZHEIMERS DISEASE	☐ YES	☐ NO	FREQUENT HEADACHE	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO	LIVER DISEASE	☐ YES	☐ NO
HEPATITIS A	☐ YES	☐ NO	STROKE	☐ YES	☐ NO
ANAPHYLAXIS	☐ YES	☐ NO	BRUISE EASILY	☐ YES	☐ NO
HEPATITIS B OR C	☐ YES	☐ NO	LOW BLOOD PRESSURE	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO	CANCER	☐ YES	☐ NO
RHEUMATIC FEVER	☐ YES	☐ NO	THYROID DISEASE	☐ YES	☐ NO
ANGINA	☐ YES	☐ NO	CHEMOTHERAPY	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO	HEART ATTACK/FAILURE	☐ YES	☐ NO
EPILEPSY/SEIZURES	☐ YES	☐ NO	OSTEOPOROSIS	☐ YES	☐ NO
SCARLET FEVER	☐ YES	☐ NO	TUBERCULOSIS	☐ YES	☐ NO
ARTIFICIAL HEART VALVE	☐ YES	☐ NO	COLD SORES	☐ YES	☐ NO
EXCESSIVE BLEEDING	☐ YES	☐ NO	HEART MURMUR	☐ YES	☐ NO
ARTIFICIAL JOINT	☐ YES	☐ NO	PAIN IN JAW JOINTS	☐ YES	☐ NO
ASTHMA	☐ YES	☐ NO	CONG. HEART DISORDER	☐ YES	☐ NO
FAINTING SPELLS/DIZZINESS	☐ YES	☐ NO	PACEMAKER	☐ YES	☐ NO
SINUS TROUBLE	☐ YES	☐ NO	HEART TROUBLE/DISEASE	☐ YES	☐ NO
BLOOD DISEASE	☐ YES	☐ NO	PSYCHIATRIC CARE	☐ YES	☐ NO

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ______________________________

DENTAL HISTORY

WHO WAS THE LAST DENTIST YOU HAVE SEEN? ______________________________

WHEN? ______________________________

WHO REFERRED YOU TO OUR OFFICE? ______________________________

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 ______________

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