Unique Dental Care, Pllc

MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

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.

PLEASE CIRCLE ALL YES or NO QUESTIONS…

Are you under a physician's care now?	Yes	No	If yes: _____
Have you ever been hospitalized or had a major operation?			If yes: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes: _____
Do you take, or have you taken, PhenFen or Redux?	Yes	No	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosophonates?	Yes	No	If yes: _____
Are you on a special diet?	Yes	No	If yes: _____
Do you use tobacco?	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 _____

Do you use controlled substances? Yes No If yes: _____

Other? Yes No If yes: _____

Do you have, or have you had any of the following? **(*Please check all that apply)**

AIDS/HIV Positive		Cortisone Medicine		Hemophilia		Recent Weight Loss	
Alzheimer's Disease		Diabetes		Hepatitis A		Renal Dialysis	
Anaphylaxis		Drug Addiction		Hepatitis B or C		Rheumatic Fever	
Anemia		Easily Winded		Herpes		Rheumatism	
Angina		Emphysema		High Blood Pressure		Scarlet Fever	
Arthritis/Gout		Epilepsy or Seizures		High Cholesterol		Shingles	
Artificial Heart Valve		Excessive Bleeding		Hives or Rash		Sickle Cell Disease	
Artificial Joint		Excessive Thirst		Hypoglycemia		Sinus Trouble	
Asthma		Fainting or Dizziness		Irregular Heartbeat		Spina Bifida	
Blood Disease		Frequent Cough		Kidney Problems		Stomach/Intestinal Disease	
Blood Transfusion		Frequent Diarrhea		Leukemia		Stroke	
Breathing Problems		Frequent Headaches		Liver Disease		Swelling of Limbs	
Bruise Easily		Genital herpes		Low Blood Pressure		Thyroid Disease	
Cancer		Glaucoma		Lung Disease		Tonsillitis	
Chemotherapy		Hay Fever		Mitral Valve Prolapse		Tuberculosis	
Chest Pains		Heart Attack/Failure		Osteoporosis		Tumors or Growths	
Cold Sores/Fever Blisters		Heart Murmur		Pain in Jaw Joints		Ulcers	
Congenital Heart Disorder		Heart Pacemaker		Parathyroid Disease		Venereal Disease	
Convulsions		Heart Trouble/Disease		Psychiatric Care		Any serious illness not listed	
Yellow Jaundice		Hemophilia		Radiation Treatments		If yes: _____	

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:

X _____ Date: _____