Austin Dental

Medical History

Patient Name: Birth Date: Date Created:

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

Physician's name and phone number?	☐	If yes
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever had any major surgeries?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Please list any prescription medications you are taking.	○ Yes ○ No	If yes
Do you use any forms of tobacco?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Penicillin ☐ Acrylic ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you have any allergies not listed above? ○ Yes ○ No If yes

General Health

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No
Hepatitis (A,B, or C)	○ Yes ○ No	Anaphylaxis (Shock)	○ Yes ○ No	Renal Dialysis	○ Yes ○ No	Anemia	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Breathing Problems	○ Yes ○ No
Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Cancer	○ Yes ○ No	Chemotherapy	○ Yes ○ No
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No				

Cardiovascular

Do you have, or have you had, any of the following?

Heart Disease	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pacemaker	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Bleed easily?	○ Yes ○ No
Hemophilia	○ Yes ○ No	Heart Attack	○ Yes ○ No	Stroke	○ Yes ○ No		

Have you ever had any serious illness not listed ○ Yes ○ No 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:_____