Active Medical History

Name: ______________________ Birth Date: _______________

Note: Dental personnel primarily treat the area in and around your mouth. The mouth is part of your entire body. Health problems that you may have, or medication that you are taking, could have an important interrelationship with the dentistry you will receive.

Yes	No	Question	If Yes, please describe:
		Are you under a physician's care now?	Who: Last Seen:
		Have you ever been hospitalized or had a major operation?	
		Have you ever had a serious head or neck injury?	
		Are you taking any medications, prescribed or not?	
		Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	
		Do you Pre-Med for dental treatment?	Why?
		Are you anxious about dental treatment?	
		Are you happy with your smile?	
		Do you use tobacco?	
		Do you snore?	
		Do you feel tired a lot?	
		Has anybody observed you quit breathing during your sleep?	

Women Only: please indicate if you are……

- ☐ Pregnant or Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Metal
- ☐ Penicillin
- ☐ Latex
- ☐ Codeine
- ☐ Sulfa Drugs
- ☐ Acrylic
- ☐ Local Anesthetics
- ☐ Other: ______________________

Do you use controlled substances? ☐ Yes: ______________ ☐ No

Please fill out back of form>

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive			Cortisone Medicine			Hemophilia			Radiation Treatment		
Alzheimer's Disease			Diabetes			Recent Weight Loss			Anaphylaxis		
Drug Addiction			Hepatitis B, C or A			Renal Dialysis			Anemia		
Easily Winded			Rheumatic Fever			Angina			Emphysema		
High Blood Pressure			Rheumatism			Arthritis/Gout			Epilepsy or Seizures		
Scarlet Fever			Artificial Heart Valve			Excessive Bleeding			Hives or Rash		
Shingles			Artificial Joint			Excessive Thirst			Hypoglycemia		
Sickle Cell Disease			Asthma			Fainting Spells/ Dizziness			Irregular Heartbeat		
Sinus Trouble			Blood Disease			Frequent Cough			Kidney Problems		
Blood Transfusion			Leukemia			Gastrointestinal Diseases			Breathing Problems		
Frequent Headaches			Liver Disease			Stroke			Bruise Easily		
Low Blood Pressure			Swelling of Limbs			Cancer			Lung Disease		
Thyroid Disease			Chemotherapy			Mitral Valve Prolapse			Chest Pains		
Heart Attack or Failure			Osteoporosis			Tuberculosis			Cold Sores		
Heart Murmur			Pain in Jaw Joint			Tumors or Growths			Congenital Heart Disorder		
Heart Pacemaker			Parathyroid Disease			Ulcers			Convulsions		
Heart Trouble/Disease			G.E.R.D.			Sjorgens			Dry Mouth		
Do you have any illness or condition not listen above?						Yes:					No

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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature or Patient, Parent or Guardian:

____ Date: _____________