

## Adult/Child Medical/ Dental History Update

Although dental personnel primarily treat the area 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.

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| 1. Have you ever taken Fosamax, Boniva, Actonel or any other Medication containing Bisphosphonates?              | <b>YES NO</b> | If Yes _____ |
| 2. Are you under a Primary Care Provider now? If yes, please List the Physician's Name/ Clinic and Phone Number. | <b>YES NO</b> | If Yes _____ |
| 3. Have you ever been Hospitalized or had a major operation? If yes, please explain.                             | <b>YES NO</b> | If Yes _____ |
| 4. Are you taking any medications, pills or Drugs? If yes, please list to the right.                             | <b>YES NO</b> | If Yes _____ |
| 5. Do you require antibiotics premedication before Dental Treatment? If yes, please list.                        | <b>YES NO</b> | If Yes _____ |
| 6. Do you take a Blood Thinner? If yes, please list.   | <b>YES NO</b> | If Yes _____ |
| 7. Do you use tobacco, chew or vape?   | <b>YES NO</b> | If Yes _____ |

**Women: Are you.... (please circle one)**

Pregnant?    Nursing?    Taking Oral Contraceptives?    How many Months Pregnant? \_\_\_\_\_

**Are you ALLERGIC to any of the following? (please circle that apply)**

Aspirin    Penicillin    Codeine    Acrylic    Metal    Latex Gloves    Sulfa Drugs    Local Anesthetic  
 Blue Dye    Other Know Allergies not listed above? \_\_\_\_\_

Do you use Controlled Substances **YES NO**

**Do you have, or have you had, any of the following? (please circle that apply)**

AIDS/HIV POSITIVE <b>YES NO</b> Anaphylaxis <b>YES NO</b> Artificial Joint <b>YES NO</b> Breathing Problems <b>YES NO</b> Cold sores/ Fever Blister <b>YES NO</b> Drug Addiction <b>YES NO</b> Excessive Bleeding <b>YES NO</b> Heart Attack/ Failure <b>YES NO</b> Heart Trouble/ Disease <b>YES NO</b> High Blood Pressure <b>YES NO</b> Liver Disease <b>YES NO</b> Pain in Jaw Joints <b>YES NO</b> Sinus Trouble <b>YES NO</b> Stroke <b>YES NO</b> High Cholesterol <b>YES NO</b> Mitral Value Prolapse <b>YES NO</b> Dry Mouth <b>YES NO</b>	Alzheimer's Disease <b>YES NO</b> Artificial Heart Valve <b>YES NO</b> Asthma <b>YES NO</b> Cancer <b>YES NO</b> Diabetes <b>YES NO</b> Epilepsy or Seizures <b>YES NO</b> Excessive Thirst <b>YES NO</b> Heart Murmur <b>YES NO</b> Hepatitis B or C <b>YES NO</b> Kidney Problems <b>YES NO</b> Lung Disease <b>YES NO</b> Psychiatric Care <b>YES NO</b> Stomach/Intestinal Disease <b>YES NO</b> Tumors or Growths <b>YES NO</b> Osteoporosis or Osteopenia <b>YES NO</b> Head or Neck Radiation/Chemo <b>YES NO</b>
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Have you ever had any serious illness not listed above? If yes, please explain. **YES NO** If Yes \_\_\_\_\_  
 Do you have any particular dental concerns? If yes, please explain. **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 statuses.

Signature of Patient, Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_