Madison Family Dental Medical History

Patient Name_____

Although dental personnel primarily treat the area in and around 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 honestly.

Are you under a physician's care now?		□Yes □ No
Have you ever been hospitalized or had a major operation?	□Yes □ No	If Yes, please explain:_____
Have you ever 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 explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	□Yes □ No	If Yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	□Yes □ No	
Are you on a special diet?	□Yes □ No	
Do you use tobacco?	□Yes □ No	
Do you use controlled substances?	□Yes □ No	

WOMEN: Are you ~

Pregnant/Trying to get Pregnant? □Yes □No Taking Oral Contraceptives? □Yes □No Nursing? □Yes □No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Sulfa Drugs
□ Other _____

Check if you have, or have had, any of the following:

□ AIDS/HIV Positive
□ Alzheimer's Disease
□ Anaphylaxis
□ Anemia
□ Angina
□ Arthritis/Gout
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Breathing Problem
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Cold Sores/Fever Blisters
□ Congenital Heart Disorder
□ Convulsions
□ Cortisone Medicine
□ Diabetes
□ Drug Addiction
□ Easily Winded
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/Dizziness
□ Frequent Cough
□ Frequent Diarrhea
□ Frequent Headaches
□ Genital Herpes
□ Glaucoma
□ Hay Fever
□ Heart Attack
□ Heart Murmur
□ Heart Pacemaker
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High blood Pressure
□ High cholesterol
□ Hives or Rash
□ Hypoglycemia
□ Irregular Heartbeat
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Lung Disease
□ Mitral Valve Prolapse
□ Osteoporosis
□ Pain in Jaw Joints
□ Parathyroid Disease
□ Psychiatric Care
□ Radiation Treatments
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Spina Bifida
□ Stomach/Intestinal Disease
□ Stroke
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Venereal Disease
□ Yellow Jaundice

Have you ever had any serious illness not listed above? □Yes □No _____

To the best of my knowledge, the questions on this for have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____Date_____