Belfair Dental Care
Medical History

Patient Name: _____ Birth Date: ____/____/_____

1. Are you under a physician's care now? ☐ Yes ☐ No If Yes: _____

2. Have you ever been hospitalized for a major operation? ☐ Yes ☐ No If Yes: _____

3. Have you ever had a serious head or neck injury? ☐ Yes ☐ No If Yes: _____

4. Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If Yes: _____

_____

5. Have you ever taken Fosamax, Boniva, Actonel or other medications containing bisphosphates? ☐ Yes ☐ No If Yes: _____

6. Do you use tobacco? ☐ Yes ☐ No If Yes: _____

7. Do you use controlled substances? ☐ Yes ☐ No If Yes: _____

Women: Are you:

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metals	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other: _____

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia
☐ Radiation Treatments	☐ Alzheimer's Disease	☐ Diabetes
☐ Hepatitis	☐ Anaphylaxis	☐ Renal Dialysis
☐ Anemia	☐ Angina	☐ Emphysema/COPD
☐ High Blood Pressure	☐ Rheumatism	☐ Arthritis/Gout
☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Artificial Heart Valve
☐ Excessive Bleeding	☐ Shingles	☐ Artificial Joint
☐ Hypoglycemia	☐ Sickle Cell Disease	☐ Asthma
☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Kidney Problems
☐ Blood Transfusion	☐ Stomach/Intestinal Disease	☐ Frequent Headaches
☐ Liver Disease	☐ Stroke	☐ Low Blood Pressure
☐ Cancer	☐ Glaucoma	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse
☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Pain in Jaw	☐ Congenital Heart Disorder
☐ Heart Pacemaker		

Have you ever had any serious illness not listed? ☐ Yes ☐ No If Yes: _____

Additional Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing misinformation 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: _____ Date: _____