Medical History

Patient Name:_____ Preferred Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____Social Security#_____

Dental Insurance: Carrier_____ ID#_____ Phone#_____

Are you under a physician's care now? ☐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 ☐Codiene ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs ☐ None

☐Other If yes, Please explain_____

Do you have any of the following?

AIDS/HIV Positive ☐Yes ☐No	Cortisone Medicine ☐Yes ☐No	Hemophilia ☐Yes ☐No	Radiation Treatment ☐Yes ☐No
Alzheimer's Disease ☐Yes ☐No	Diabetes ☐Yes ☐No	Hepatitis A ☐Yes ☐No	Recent Weight Loss ☐Yes ☐No
Anaphylaxis ☐Yes ☐No	Drug Addiction ☐Yes ☐No	Hepatitis B or C ☐Yes ☐No	Renal Dialysis ☐Yes ☐No
Anemia ☐Yes ☐No	Easily Winded ☐Yes ☐No	Herpes ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Angina ☐Yes ☐No	Emphysema ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Rheumatism ☐Yes ☐No
Arthritis/Gout ☐Yes ☐No	Epilepsy/Seizures ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Excessive Bleeding ☐Yes ☐No	Hives/Rash ☐Yes ☐No	Shingles ☐Yes ☐No
Artificial Joint ☐Yes ☐No	Excessive Thirst ☐Yes ☐No	Hypoglycemia ☐Yes ☐No	Sickle Cell Disease ☐Yes ☐No
Asthma ☐Yes ☐No	Fainting/Dizziness ☐Yes ☐No	Irregular Heartbeat ☐Yes ☐No	Sinus Trouble ☐Yes ☐No
Blood Disease ☐Yes ☐No	Frequent Cough ☐Yes ☐No	Kidney Problems ☐Yes ☐No	Spina Bifida ☐Yes ☐No
Blood Transfusion ☐Yes ☐No	Frequent Diarrhea ☐Yes ☐No	Leukemia ☐Yes ☐No	Stomach/Intestinal Disease ☐Yes ☐No
Breathing Problem ☐Yes ☐No	Frequent Headaches ☐Yes ☐No	Liver Disease ☐Yes ☐No	Stroke ☐Yes ☐No
Bruise Easily ☐Yes ☐No	Genital Herpes ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Swelling of Limbs ☐Yes ☐No
Cancer ☐Yes ☐No	Glaucoma ☐Yes ☐No	Lung Disease ☐Yes ☐No	Thyroid Disease ☐Yes ☐No
Chemotherapy ☐Yes ☐No	Hay Fever ☐Yes ☐No	Mitral Valve Prolapse ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Chest Pains ☐Yes ☐No	Heart Attack/Failure ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Cold Sores/Fever Blisters ☐Yes ☐No	Heart Murmur ☐Yes ☐No	Pain in Jaw/Joints ☐Yes ☐No	Tumors or Growths ☐Yes ☐No
Congenital Heart Disorder ☐Yes ☐No	Heart Trouble/Disease ☐Yes ☐No	Parathyroid Disease ☐Yes ☐No	Ulcers ☐Yes ☐No
Convulsions ☐Yes ☐No	Heart Pacemaker ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	Venereal Disease ☐Yes ☐No

Have you ever had a serious illness not listed? ☐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 (or patient's) health. It is my responsibility to inform the Brier Creek Smiles Dentistry of any changes in medical status.

SIGNATURE OF PATIENT/PARENT/GUARDIAN_____ DATE_____