Time 9:30 AM | Stratford Dental - Brian Evans, D.D.S. | Date 1/26/2019

Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and 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.

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
ARE YOU TAKING ANY MEDICATIONS, PILLS, OR DRUGS?	○ Yes ○ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Do you use tobacco?	○ Yes ○ No		

Women: Are you...

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

Are you allergic to any of the following?

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

Do you use controlled substances?	○ Yes ○ No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following? (Within the past ten years)

Acid Reflex ○ Yes ○ No	Diabetes Type I ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
AIDS/HIV Positive ○ Yes ○ No	Diabetes Type II ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Dialysis ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Rheumatoid Arthritis ○ Yes ○ No
Arthritis ○ Yes ○ No	Emphysema ○ Yes ○ No	Hyperthyroidism ○ Yes ○ No	Rheumatism ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Hypothyroidism ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Shingles ○ Yes ○ No
Asthma ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Irregular Heart Beat ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Atrial Fibrillation ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Leukemia ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Stroke ○ Yes ○ No
Cancer (type) ○ Yes ○ No	GERD ○ Yes ○ No	Lung Disease ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
_____	Glaucoma ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Transient Ischemic Attack (TIA) ○ Yes ○ No
Chemotherapy (last tx) ○ Yes ○ No	Hay Fever ○ Yes ○ No	Obstructive Sleep Apnea (OSA) ○ Yes ○ No	Tonsillitis ○ Yes ○ No
_____	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Chest Pain ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Congenital Heart Disease ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Convulsions ○ Yes ○ No	Hemophilia ○ Yes ○ No		
COPD ○ Yes ○ No			
Cortisone Medicine ○ Yes ○ No			

Have you ever had any serious illness not listed above?	○ Yes ○ No	If yes	

Other Contacts

Primary Care Physician (name and phone number):	☐	If yes	
In Case of Emergency (name and phone number):	☐	If yes	

Comments:

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 status.

Signature of Patient, Parent or Guardian:

X Date:_____