Bismarck FAMILY DENTAL PC

MEDICAL HISTORY

Patient Name: _____

Birth Date: _____

- List your current physician(s), clinic(s), and their respective phone numbers:
  -
  -
  -
- Date of your last medical/physical examination: _____
- What, if any, medical conditions are you currently being treated for?
  -
  -
  -
- Are you taking any prescription, over-the-counter, natural, or recreational medications, pills, or drugs? If yes, list them:
  -
  -
  -

			If yes, please explain:
Have you ever been hospitalized?	○ Yes	○ No	_____
Have you ever had a serious head or neck injury?	○ Yes	○ No	_____
Have you received radiation to the head or neck for cancer treatment?	○ Yes	○ No	_____
Do you use controlled substances?	○ Yes	○ No	_____
Have you ever taken oral or IV bisphosphonates (e.g., Fosamax, Boniva, Prolia)? What time period?	○ Yes	○ No	_____
Do you take any other medications to treat osteoporosis?	○ Yes	○ No	_____
Are you on any blood thinner, anti-coagulant, or anti-platelet medications?	○ Yes	○ No	_____
Have you taken steroids in the past 2 years for 10-14 days or longer (e.g., prednisone, cortisone)?	○ Yes	○ No	_____
Have you ever taken an antibiotic premedication for dental treatment for any reason?	○ Yes	○ No	_____
Do you have any joint replacements or organ transplants?	○ Yes	○ No	_____
Do you use tobacco products (e.g., cigarettes, cigars, smokeless tobacco, etc.)?	○ 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 anesthetic
  - ○ Other allergies? If yes, list them:

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

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

❖ Have you ever had any serious illness not listed above? Yes No If yes, explain: _____

DENTAL HISTORY

❖ When was your last dental visit? _____

❖ What treatment was provided? _____

If yes, please explain:

❖ Have you ever had any orthodontic treatment (braces)? ○ Yes ○ No _____

❖ Have you had your third molars (wisdom teeth) removed, and if so, by whom? ○ Yes ○ No _____

❖ Have you been treated for TMJ (jaw joint) dysfunction? ○ Yes ○ No _____

❖ Do you have a history of periodontal (gum) disease? ○ Yes ○ No _____

❖ Have you seen any other dental specialist for treatment? ○ Yes ○ No _____

❖ Do you have a history of xerostomia (dry mouth)? ○ Yes ○ No _____

❖ Do you have anxiety about dental treatment? ○ Yes ○ No _____

❖ Are you happy with the current appearance of your smile? ○ 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 dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

_____ Date: _____