PREMIERE DENTAL

Medical History Form

Patient Name: _____

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

1.) Are you under a physician's care now? YES/NO
2.) Have you ever been hospitalized or had a major operation? YES/NO
3.) Have you had a serious head or neck injury? YES/NO
4.) Are you taking any medications, pills, or drugs? YES/NO
If yes, please explain: _____

5.) Do you take or have taken, Phen-Fen or Redux? YES/NO
6.) Have you ever taken Fosamax, Bonica, Actonel or any other medications containing bisphosphonates?
YES/NO
7.) Are you on a special diet? YES/NO
8.) Do you use tobacco? YES/NO
9.) Do you use controlled substances? YES/NO

Women: Are you...

- Pregnant/Trying to get pregnant? YES/NO
- Nursing? YES/NO
- Taking Oral contraceptives? YES/NO

☐

Are you allergic to any of the following? Check here only if NO for all

- Aspirin Y ☐ N ☐
- Codeine Y ☐ N ☐
- Metal Y ☐ N ☐
- Sulfa drugs Y ☐ N ☐
- Penicillin Y ☐ N ☐
- Acrylic Y ☐ N ☐
- Latex Y ☐ N ☐
- Local Anaesthetics Y ☐ N ☐
- Other Y N _____

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Do you have, or have had any of the following? Mark the appropriate response

MARK THIS BOX IF THE ANSWER IS NO TO ALL ☐

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

Have you ever had any serious illness not listed above? _____

Signature: _____ Date: _____

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