MEDICAL HISTORY

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 treatment you will receive. Thank you for answering the following questions.

Are you under a physicians care now? If yes, condition:

Physicians Name and Phone Number:

Have you ever had any complications following dental treatment? If yes, please explain:

_____

_____

Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain:

Have you ever had a serious head or neck injury? If yes, please explain:

Are you taking medications, pills or drugs? If yes, please list drug name-dosage—and purpose:

_____

_____

_____

_____

Do you take or have you ever taken Phen-Fen or Redux?

Do you take or have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?

Are you on a special diet?

Do you use tobacco products?

Do you use controlled substances?

Please circle any of the following that you are allergic to: ASPIRIN PENICILLIN SULFA CODEINE LATEX LOCAL ANESTHETICS ACRYLIC METAL

Do you have any allergies to any other medications or substances? If yes, please list:

WOMEN: Are you pregnant or trying to get pregnant? Due Date:

Are you nursing? Are you taking oral contraceptives? If yes, Name and dosage:

Please circle any of the following that you have or have had in the past:

AIDS/HIV POSITIVE
ALZHEIMER'S
ANAPHYLAXIS
ANEMIA
ANGINA
ARTHIRITIS
ARTIFICIAL HEART VALVE
ARTIFICIAL JOINT
ASTHMA
BLOOD DISEASE
BLOOD TRANSFUSION
BREATHING PROBLEM
BRUISE EASILY
CANCER
CHEMOTHERAPY
CHEST PAINS
COLD SORES
CONGENITAL HEART DISORDER
CONTACT LENSES
CONVULSIONS
CORTISONE MEDICINE
DIABETES
DIZZINESS
DRUG ADDICTION
EMPHYSEMA
EPILEPSY
EXCESSIVE BLEEDING
EXCESSIVE THIRST
FAINITNG SPELLS
FEVER BLISTERS
FREQUENT COUGH
FREQUENT DIARRHEA
FREQUENT HEADACHES
GENITAL HERPES
GLAUCOMA
GROWTHS
HAY FEVER
HEART ATTACK/FAILURE
HEART MURMUR
HEART PACEMAKER
HEART TOUBLE/ DISEASE
HEMOPHILIA
HEPATITIS A, B, OR C
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
HIVES OR RASH
HYPOGLYCEMIA
IRREGULAR HEARTBEAT
JAUNDICE
KIDNEY DISEASE
LATEX SENSITIVITY
LEUKEMIA
LIVER DISEASE
LOW BLOOD PRESSURE
LUNG DISEASE
MENTAL DISORDERS
MITRAL VALVE PROLAPSE
OSTEOPOROSIS
NERVOUS DISORDERS
PAIN IN JAW JOINTS
PARATHYROID DISEASE
PSYCHIATRIC CARE
RHEUMATISM
RADIATION TREATMENT
RESPIRATORY PROBLEMS
RECENT WEIGHT LOSS
RHEUMATIC FEVER
RENAL DIALYSIS
SCARLET FEVER
SHINGLES
SICKLE CELL DISIEASE
SINUS PROBLEMS
SLEEP APNEA/SNORING
SMOKE/CHEW TOBACCO
SPINABIFIDA
STOMACH/INTESTINAL DISEASE
STROKE
SWELLING OF LIMBS
THYROID DISEASE
TONSILITIS
TUBERCULOSIS
TUMORS
ULCERS
VENEREAL DISEASE

OTHER:_____

Do you have or have you had any serious illness not listed above? If yes, explain: _____

_____

Do you have any health conditions that need further clarification? If yes, explain: _____

_____

To the best of my knowledge, the preceding information provided is true and correct. I understand that not providing necessary information or providing false or incorrect information can be dangerous to my (or patient's) health. I also understand that it is my responsibility to inform Dr. Weimer and staff of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____

DATE: _____