MIDDLE TENNESSEE
PROSTHODONTICS

MEDICAL HISTORY

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Print 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.

Question			
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: ______
Are you on a special diet?	☐ Yes	☐ No	
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

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

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

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

Have you ever had any serious illness not listed ☐ Yes ☐ No

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 Date