GROVE PARK DENTAL - MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

PATIENT NAME ____ **DOB** ____/____/________

Are you under a physician's care now? [ ] Y [ ] N **PHYSICIAN'S NAME AND PHONE #**____

Have you ever been hospitalized or had a major operation? [ ] Y [ ] N **IF YES, EXPLAIN** ____

Have you ever had a serious neck or head injury? [ ] Y [ ] N **IF YES, EXPLAIN** ____

Are you taking any medications, pills, or drugs? [ ] Y [ ] N **IF YES, LIST** ____

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Do you take, or have you taken, Phen-Fen or Redux? **[ ] Y [ ] N**

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **[ ] Y [ ] N**

Are you on a special diet? **[ ] Y [ ] N**

Do you use tobacco? **[ ] Y [ ] N IF YES, LIST PRODUCT AND FREQUENCY** ____

Do you use controlled substances? **[ ] Y [ ] N**

Are you allergic to any of the following? [ ] aspirin [ ] penicillin [ ] codeine [ ] local anesthetics [ ] acrylic [ ] metal [ ] latex [ ] sulfa drugs [ ] other ____

WOMEN: Are you- pregnant/trying to get pregnant? **[ ] Y [ ] N** taking oral contraceptives? **[ ] Y [ ] N** nursing? **[ ] Y [ ] N**

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

AIDS/HIV positive	**[ ] Y [ ] N**	Epilepsy or seizures	**[ ] Y [ ] N**	Mitral Valve Prolapse	**[ ] Y [ ] N**
Alzheimer's Disease	**[ ] Y [ ] N**	Fainting spells/Dizziness	**[ ] Y [ ] N**	Osteoporosis	**[ ] Y [ ] N**
Anaphylaxis	**[ ] Y [ ] N**	Heart attack/Failure	**[ ] Y [ ] N**	Parathyroid Disease	**[ ] Y [ ] N**
Anemia	**[ ] Y [ ] N**	Heart Murmur	**[ ] Y [ ] N**	Psychiatric Care	**[ ] Y [ ] N**
Angina	**[ ] Y [ ] N**	Heart Pacemaker	**[ ] Y [ ] N**	Radiation Treatments	**[ ] Y [ ] N**
Arthritis/Gout	**[ ] Y [ ] N**	Hemophilia	**[ ] Y [ ] N**	Recent Weight Loss	**[ ] Y [ ] N**
Artificial Heart Valve	**[ ] Y [ ] N**	Hepatitis A	**[ ] Y [ ] N**	Renal Dialysis	**[ ] Y [ ] N**
Artificial Joint	**[ ] Y [ ] N**	Hepatitis B or C	**[ ] Y [ ] N**	Shingles	**[ ] Y [ ] N**
Asthma	**[ ] Y [ ] N**	Herpes	**[ ] Y [ ] N**	Sinus Trouble	**[ ] Y [ ] N**
Blood Disease	**[ ] Y [ ] N**	High Blood Pressure	**[ ] Y [ ] N**	Stomach/Intestinal dis.	**[ ] Y [ ] N**
Cancer	**[ ] Y [ ] N**	High Cholesterol	**[ ] Y [ ] N**	Stroke	**[ ] Y [ ] N**
Chemotherapy	**[ ] Y [ ] N**	Hypoglycemia	**[ ] Y [ ] N**	Thyroid Disease	**[ ] Y [ ] N**
Cold sores/Fever blisters	**[ ] Y [ ] N**	Irregular Heartbeat	**[ ] Y [ ] N**	Tuberculosis	**[ ] Y [ ] N**
Congenital Heart Disorder	**[ ] Y [ ] N**	Kidney Problems	**[ ] Y [ ] N**	Tumors or Growths	**[ ] Y [ ] N**
Diabetes	**[ ] Y [ ] N**	Leukemia	**[ ] Y [ ] N**	Ulcers	**[ ] Y [ ] N**
Drug addiction	**[ ] Y [ ] N**	Liver Disease	**[ ] Y [ ] N**		
Emphysema	**[ ] Y [ ] N**	Low Blood Pressure	**[ ] Y [ ] N**		

Have you ever had a serious illness not listed above? **[ ] Y [ ] N IF YES, EXPLAIN** ____

COMMENTS ____

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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 my medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN ____

SIGNATURE OF DENTIST ____**DATE** ____/ ____/ _________