CAMPBELL DENTAL GROUP

Medical History

MEDICAL HISTORY

PATIENT NAME Last	First	M.I.	DATE OF BIRTH		
ADDRESS			CITY	STATE	ZIP CODE

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.

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, please explain:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain:
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes, please explain:
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes, please explain:
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	

WOMEN

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ALLERGIES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other:

HISTORY

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

AIDS/HIV Positive	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Congenital Heart Disorder	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No			
Convulsions	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No			
Cortisone Medicine	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No			
Have you ever had any serious illness not listed above?				☐ Yes	☐ No	If yes, please explain:					

COMMENTS/QUESTIONS

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