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Clarendon Dental Arts

Medical History

Patient Name:_____ Date of Birth:_____

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.

Describe:

Are you under a physician's care now? ◯ Yes ◉ No ◯ N/A _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◉ No ◯ N/A _____

Have you ever had a serious head or neck injury? ◯ Yes ◉ No ◯ N/A _____

Are you taking any medications, pills, herbal supplements, or drugs? ◯ Yes ◉ No ◯ N/A _____

Do you take or have you taken bisphosphonates? ◯ Yes ◉ No ◯ N/A Do you smoke, VAPE or chew tobacco? ◯ Yes ◉ No ◯ N/A

Are you on a special diet? ◯ Yes ◉ No ◯ N/A Do you use controlled substances? ◯ Yes ◉ No ◯ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

How much do you drink daily? Soda _____ Coffee/Tea _____ H2O _____ Alchohol _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

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

- ☐ Acid Reflux or GERD
- ☐ AIDS/HIV Positive
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cancer: Chemotherapy
- ☐ Cancer: Radiation
- ☐ Cold Sores
- ☐ Dry Mouth
- ☐ Fever Blisters
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Frequent Headaches
- ☐ Heart Condition:
  - ☐ Angina
  - ☐ Chest Pains
  - ☐ Congenital Disorder
  - ☐ Pace Maker
  - ☐ Valve Replacements
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Intestinal Disease
- ☐ Kidney Problems
- ☐ Kidney Disease
- ☐ Psychiatric Care
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumors or Growths
- ☐ Ulcers

Do you have a family history of Diabetes ☐ Heart Disease ☐ Periodontal Disease ☐ Alzheimer's ☐

Comments: _____

Today's B.P. _____ Pulse _____

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