# MILLHOPPER FAMILY DENTISTRY
## PATIENT MEDICAL HISTORY

PATIENT NAME: BIRTH DATE: TODAY'S DATE:

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 |
| 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 |
| 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 |

| | | |
|---|---|---|
| Do you use controlled substances? | ○ Yes ○ No | If yes |
| Other? | ☐ | If yes |

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

| | | | |
|---|---|---|---|
| AIDS/HIV Positive ○ Yes ○ No | Cortisone Medicine ○ Yes ○ No | Hemophilia ○ Yes ○ No | Radiation Treatments ○ Yes ○ No |
| Alzheimer's Disease ○ Yes ○ No | Diabetes ○ Yes ○ No | Recent Weight Loss ○ Yes ○ No | Anaphylaxis ○ Yes ○ No |
| Drug Addiction ○ Yes ○ No | Hepatitis B or C ○ Yes ○ No | Renal Dialysis ○ Yes ○ No | Anemia ○ Yes ○ No |
| Herpes ○ Yes ○ No | Rheumatic Fever ○ Yes ○ No | Emphysema ○ Yes ○ No | High Blood Pressure ○ Yes ○ No |
| Epilepsy or Seizures ○ Yes ○ No | Artificial Heart Valve ○ Yes ○ No | Excessive Bleeding ○ Yes ○ No | Hives or Rash ○ Yes ○ No |
| Shingles ○ Yes ○ No | Artificial Joint ○ Yes ○ No | Excessive Thirst ○ Yes ○ No | Hypoglycemia ○ Yes ○ No |
| Sickle Cell Disease ○ Yes ○ No | Asthma ○ Yes ○ No | Fainting Spells/Dizziness ○ Yes ○ No | Irregular Heartbeat ○ Yes ○ No |
| Sinus Trouble ○ Yes ○ No | Blood Disease ○ Yes ○ No | Kidney Problems ○ Yes ○ No | Leukemia ○ Yes ○ No |
| Stomach/Intestinal Disease ○ Yes ○ No | Liver Disease ○ Yes ○ No | Stroke ○ Yes ○ No | Bruise Easily ○ Yes ○ No |
| Low Blood Pressure ○ Yes ○ No | Swelling of Limbs ○ Yes ○ No | Cancer ○ Yes ○ No | Lung Disease ○ Yes ○ No |
| Thyroid Disease ○ Yes ○ No | Chemotherapy ○ Yes ○ No | Seasonal Allergies ○ Yes ○ No | Mitral Valve Prolapse ○ Yes ○ No |
| Chest Pains/Angina ○ Yes ○ No | Heart Attack/Failure ○ Yes ○ No | Osteoporosis ○ Yes ○ No | Tuberculosis ○ Yes ○ No |
| Cold Sores/Fever Blisters ○ Yes ○ No | Heart Murmur ○ Yes ○ No | Pain in Jaw Joints ○ Yes ○ No | Tumors or Growths ○ Yes ○ No |
| Congenital Heart Disorder ○ Yes ○ No | Heart Pacemaker/Defibrillator ○ Yes ○ No | Ulcers ○ Yes ○ No | Heart Trouble/Disease ○ Yes ○ No |
| Psychiatric Care ○ Yes ○ No | Venereal Disease ○ Yes ○ No | | |

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments: