West Bend Dental

Medical History

PATIENT NAME _____ BIRTH DATE _____

PERSONAL PHYSICIAN _____ PHONE NO. _____

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 allergic to any of the following?

❍ Asprin ❍ Penicillin ❍ Local Anesthetics ❍ Acrylic ❍ Metal ❍ Latex ❍ Sulfa Drugs ❍ Other

If yes, please explain: _____

Have you ever had an artificial joint or joint replacement? ❍ Yes ❍ No
If yes, please explain: _____

Have you ever had a valve replacement ❍ Yes ❍ No
If yes, please explain: _____

Are you taking a blood thinner? ❍ Yes ❍ No
If yes, please explain: _____

Have you taken Foxmax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ Yes ❍ No
If yes, please explain: _____

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: _____

Women: Are you...

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

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

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

Have you ever had any serious illness not listed above? ❍ Yes ❍ No
If yes, please explain: _____

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.

I understand that my dental insurance carrier may pay less than the actual bill for services. I will be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____