Clifton Park Dental
Your family dentists in Clifton Park, NY

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MEDICAL HISTORY

PATIENT NAME: _____ **BIRTHDATE:** _____

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.

1. Are you under a physician's care now?
◯Yes ◯No If yes, please explain: _____

2. Have you ever been hospitalized or had a major operation?
◯Yes ◯No If yes, please explain: _____

3. Have you had an orthopedic total joint (hip, knee, elbow, etc) replacement
◯Yes ◯No If yes, please explain: _____

4. Do you require antibiotics prior to dental treatment as a result of your joint replacement or for any other reason?
◯Yes ◯No If yes, please explain: _____

5. Do you or have you taken oral medication or received IV treatment for osteoporosis?
◯Yes ◯No If yes, please explain: _____

6. Have you ever had a serious head or neck injury?
◯Yes ◯No If yes, please explain:

7. Do you take, or have taken, Phen-Fen or Redux? ◯ Yes ◯ No
8. Do you use tobacco? ◯ Yes ◯ No
9. Do you use controlled substances? ◯ Yes ◯ No
10. Do you drink alcoholic beverages? ◯ Yes ◯ No How much per week?_____

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

Allergies: Are you allergic to any of the following?

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

If yes, please explain: _____

Medications: Please list any medications, pills, or drugs you are currently taking: _____

_____

_____

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

Acid Reflux	Cancer	Frequent Cough	Hypoglycemia	Rheumatism
AIDS/HIV Positive	Chemotherapy	Frequent Diarrhea	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Chest Pains	Frequent Headaches	Kidney Problems	Shingles
Anaphylaxis	Cold Sores/Fever Blisters	Genital Herpes	Leukemia	Sickle Cell Disease
Anemia	Congenital Heart Disorder	Glaucoma	Liver Disease	Sinus Trouble
Angina	Convulsions	Hay Fever/Seasonal	Low Blood Pressure	Spina Bifida
Arteriosclerosis	Cortisone Medicine	Heart Attack/Failure	Lung Disease	Stomach/Intestinal Disease
Arthritis/Gout	Damaged Heart Valves	Heart Murmur	Mitral Valve Prolapse	Stroke
Artificial Heart Valve	Diabetes	Heart Pacemaker	Osteoporosis	Swelling of Limbs
Artificial Joint	Drug Addiction	Heart Trouble/Disease	Pain in Jaw Joints	Thyroid Disease
Asthma	Easily Winded	Hemophilia	Parathyroid Disease	Tonsillitis
Autoimmune Disease	Emphysema	Hepatitis	Psychiatric Care	Tuberculosis
Blood Disease	Epilepsy or Seizures	Hepatitis B or C	Radiation Treatments	Tumors or Growths
Blood Transfusion	Excessive Bleeding	Herpes	Recent Weight Loss	Ulcers
Breathing Problem	Excessive Thirst	High Blood Pressure	Renal Dialysis	Venereal Disease
Bruise Easily	Fainting Spells/Dizziness	Hives or Rash	Rheumatic Fever	Yellow Jaundice

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.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

_____ Date _____