Willow Tree Dental Group

MEDICAL HISTORY

PATIENT NAME _____ D.O.B._____ 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 ❍ N/A Name of Physician_____

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

Do you ever have problems laying back? ❍ Yes ❍ No ❍ N/A _____

Are you in Pain? ❍ Yes ❍ No ❍ N/A _____

Are you currently taking or have taken Biophosphinate Medications (Fosmax, Boniva, Actonel, etc.)? ❍ Yes ❍ No ❍ N/A _____

Are you taking any medications? If so please list. ❍ Yes ❍ No ❍ N/A _____

Are you on a special diet? ❍ Yes ❍ No ❍ N/A _____

Do you use/have used tobacco? ❍ Yes ❍ No ❍ N/A _____

Do you use/have used controlled substances? ❍ Yes ❍ No ❍ N/A _____

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 ☐ Local Anesthetics ☐ Other_____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder*	☐ Hay Fever	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Murmur*	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Pace Maker*	☐ Lung Disease	☐ Stroke
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Disease	☐ Mitral Valve Prolapse*	☐ Swelling of Limbs
☐ Artificial Joints*	☐ Easily Winded	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Asthma	☐ Emphysema	☐ Hepatitis A	☐ Parathyroid Disease	☐ Tonsillitis (chronic)
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tuberculosis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Herpes	☐ Radiation Treatments	☐ Tumor or Growths
☐ Bruise Easily	☐ Excessive Thirst	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Ulcers
☐ Cancer	☐ Fainting Spells/Dizziness	☐ Hive or Rash	☐ Renal Dialysis	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Cough	☐ Hypoglycemia	☐ Rheumatic Fever*	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ❍ Yes ❍ No ❍ N/A _____

Comments: _____

_____

*Condition may require medication N/A - Not answered by patient

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

_____

SIGNATURE OF DOCTOR OR HYGIENIST DATE