

Powder River Dental Associates

MEDICAL HISTORY

PATIENT NAME _____

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 Dr: _____

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, or drugs? Yes No N/A List: _____

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

Do you use tobacco? Yes No N/A

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

Are you taking any medication for the treatment of bone density? Yes No Aredia Fosamax Didronel Actonel
 Skelid Boniva Other _____

Are you taking any medication to thin your blood? Yes No N/A List: _____

Are you allergic to the following: _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have, or have you had, any of the following: _____

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever* |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Insulin Dependent | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Metal
Date: _____ | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Plastic | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Virus | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Vaccine | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Venereal Disease |

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

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

Comments: _____

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