Clark Family Dental Center

MEDICAL HISTORY

Name _____

Date of birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 medication, pills, or drugs?	__ Yes __ No	If yes _____
Have you even taken Fosamax, Boniva, Actonel or any other medications containing biphosphonates?	__ Yes __ No	If yes _____
Do you use tobacco? Chew Cigarettes	__ Yes __ No	If yes, quantity _____
Do you use controlled substances?	__ Yes __ No	If yes, _____

Women: Are You ____ Pregnant/Trying to get pregnant? __ Nursing __ Taking Oral Contraceptives?

ALLERGIES: Are you allergic to any of the following?

__ Aspirin __ Penicillin __Codeine __Acrylic __Metal __ Latex __Sulfa Drugs __ Local Anesthetics

Other? _____

Please tell us about any health problems you have had _____
_____

Do you have, or have you had, any of the following? Circle all that apply

AIDS/HIV Positive	Chest pains	Frequent urination	Medication for osteoporosis
Artificial Joint	Congenital heart defect	Heart attack / disease	Organ transplant
Asthma	Current drug use, (Other than listed above)	Heart pacemaker	Pain in jaw joints
Bleeding disorders	Diabetes	Hepatitis (A), (B), (C)	Radiation treatment
Blood thinners	Epilepsy/seizures	High blood pressure	Stroke
Bruise Easily	Excessive thrist	Kidney problems	Thyroid problems
Cancer	Fainting	Liver problems	Tumors or growths
Chemotherapy	Frequent headaches	Lung disease	Yellow jaundice

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.

Name _____ Date _____