Grove
Health Dental

Medical History for: (First Name)_____ (Last 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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please look over the following questions carefully and thank you for answering completely and accurately. We look forward to your visit!

Are you under a physicians 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 fill in here: _____

Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No _____

Are you on a special diet? ○Yes ○No _____

Do you use tobacco products? ○Yes ○No What? _____ How much/day?_____

Do you use controlled substances? ○Yes ○No What?_____

Women, are you: Pregnant/Trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Are you allergic to any of the following?

☐Asprin ☐Penicillin ☐Codeine ☐Acrylic ☐Metals ☐Latex ☐Local Anesthetic

Are you allergic to anything else? ○Yes ○No Please explain _____

Please check (√) if you have, or have ever had, any of the following?

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

Have you had any serious illness not listed above? □ If yes, please explain _____

Are you now taking, or have you ever taken, prescribed medications called bisphophonates? ○Yes ○No

Do you have Pagets Disease of the bone? ○Yes ○No

Have you ever had Muptiple Myeloma? ○Yes ○No

Have you ever had any malignancy of the bones? ○Yes ○No

Do you have osteoporosis? ○Yes ○No

Thank you for answering this form accurately and to the best of your knowledge. Please understand that providing incorrect information could be dangerous to your health. It is your responsibility to inform Grove Health Dental of any changes in your medical status.