Medical History

Although our Dental Team primarily treats areas in and around your mouth, the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible. Thank You!

Are you under a physician's 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: _____
Do you take, or have you taken Bisphosphonates (i.e. Fosamax)? ☐ Yes ☐ No If yes, please explain:
_____
Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____
Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____
Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____
Please list any medications, pills, or drugs you are taking: _____
_____

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia / Blood Disorder
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma / Breathing Problems
- ☐ Blood Disease / Hemophilia
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug / Alcohol Addiction
- ☐ Dry Mouth
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hepatitis Type __
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Human Papilloma Virus (HPV)
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lumps / Swelling in Mouth
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Prolonged Bleeding
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stomach Disease
- ☐ Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment
_____
_____

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my child's) health. I will not hold Dr. Kevin Kay or any members of his Dental Team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify Dr. Kay of any changes in the above medical status.

Patient or Responsible Party Signature: X_____ Date: _____

Print Name: _____