TIME 10:23 AM DAVID A. UPPGAARD, DDS DATE 6/27/2011

# MEDICAL HISTORY

PATIENT NAME _____ Birth 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 | 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 explain: _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes | No | _____ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes | No | _____ |
| Are you on a special diet? | Yes | No | Women: Are you |
| Do you use tobacco? | Yes | No | ☐ Pregnant/Trying to get pregnant? ☐ Nursing? |
| Do you use controlled substances? | Yes | No | ☐ Taking oral contraceptives? |

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____