North Asheville Family Dentistry

Medical History Form

Name: ____ Birthdate: __________________________

Although dental personnel primary treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have, or mediation you may be taking, could have important interrelationship with the dentistry you will receive. Please answer the following questions:

Are you under a physician's/primary care doctors care now? ☐ Yes ☐ No If yes:______________________

Have you 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 medications, pills or drugs? List ALL ☐ Yes ☐ No If yes:______________________

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Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes:______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes:______________________

Are you on a special diet? ☐ Yes ☐ No If yes:______________________

Do you use tobacco? ☐ Yes ☐ No If yes:______________________

Do you use controlled substances? ☐ Yes ☐ No If yes:______________________

Are you taking Xarelto, Coumadin, or any blood thinners? ☐ Yes ☐ No If yes:______________________

Are you required to take an antibiotic prior to dental Treatment as recommended by a physician? ☐ Yes ☐ No If yes:______________________

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

Are you allergic to any of the following?

☐Asprin ☐Penicillin ☐Codeine ☐Acrylic

☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics

☐Other (list)____

Do you have, or had any of the following? (Please Circle)

AIDS/HIV	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Epilepsy or Seizures
Scarlet Fever	Artificial Heart Valve	Excessive Bleeding	Hives or Rash
Shingles	Artificial Joint	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Blood Transfusions	Leukemia	Breathing Problems
Liver Disease	Stroke	Bruise Easily	Low Blood Pressure
Cancer	Glaucoma	Lung Disease	Chemotherapy
Hay Fever	Mitral Valve Prolapse	Tonsillitis	Chest Pains
Heart Attack/Failure	Osteoporosis	Tuberculosis	Cold Sores/Fever Blisters
Heart Murmur	Pain in Jaw Joints	Tumors or Growths	Congenital Heart Disorder
Heart Pacemaker	Ulcers	Convulsions	Heart Trouble/Disease
Psychiatric Care			

Do you have, or had any serious illness not listed above? ☐ Yes ☐ No If yes:______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that proving 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: ________________________