

# Dr. Doug's Pediatric Dentistry

## Medical History

**Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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 for any condition? **Y / N** If Yes, Dr.'s Name: \_\_\_\_\_  
 Have you ever been hospitalized or had a major operation? **Y / N** If Yes \_\_\_\_\_  
 Have you ever had a serious head or neck injury? **Y / N** If Yes \_\_\_\_\_  
 Are you taking any medication, pills, drugs, homeopathic remedies (including essential oils)? **Y / N** If Yes \_\_\_\_\_  
 Do you take, or have you taken, Phen-Fen or Redux? **Y / N** If Yes \_\_\_\_\_  
 Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **Y / N** If Yes \_\_\_\_\_  
 Are you on a special diet? **Y / N** If Yes \_\_\_\_\_  
 Do you use tobacco? **Y / N** If Yes \_\_\_\_\_  
 Do you use controlled substances? **Y / N** If Yes: \_\_\_\_\_

**Women: Are you...**

Pregnant/Trying to get pregnant	Nursing	Taking oral contraceptives	N/A
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**Are you allergic to any of the following?**

Aspirin	Penicillin	Codeine	Acrylic	Metal	Latex	Sulfa Drugs	Local Anesthetics
Other: _____							

Do you have, or have you had, any of the following? (if no to most/all, draw a line down the "N" column)

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

Have you ever 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 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/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_