KENTWOOD
PREMIER DENTISTRY

MEDICAL HISTORY

PATIENT NAME_____ BIRTH DATE_____

Although our dental team primarily treats the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship to the care you will receive at our office. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	_____
Have you been hospitalized or had a major operation?	☐ Yes	☐ No	_____
Have you ever had a serious head/neck injury?	☐ Yes	☐ No	_____
Have you taken Phen-Fen or Redux?	☐ Yes	☐ No	_____
Have you taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐ Yes	☐ No	_____
Are you on a special diet?	☐ Yes	☐ No	_____
Do you smoke or chew tobacco?	☐ Yes	☐ No	_____
Do you use controlled substances?	☐ Yes	☐ No	_____
Women: Are you pregnant?	☐ Yes	☐ No	_____
Nursing?	☐ Yes	☐ No	_____
Taking oral contraceptives?	☐ Yes	☐ No	_____

Medications: _____
_____
_____

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

Do you have or have you had the following:

☐ AIDS/HIV	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's	☐ Cold Sores	☐ 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	☐ Sinus Trouble
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Spina Bifida
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Stomach/Intestine Problems
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Swelling of Limbs
☐ Blood Disease	☐ Epilepsy/Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Tonsilitis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tumors/Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatment	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives/Rash	☐ Renal Dialysis	☐ Yellow Jaundice

Other illness(es) not listed above_____

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 Kentwood Premier Dentistry of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____DATE_____