Time 3:42 PM | Eastridge Dental Associates | Date 3/2/2023

Medical History Form*

Patient Name: | Birth Date: | Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a joint replacement? (Hip, knee, etc.)	◯ 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?	◯ Yes ◯ No	If yes
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
Do youuse tobacco/controlled substances?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Allergies

Are you allergic to penicillin or any other antibiotics?	◯ Yes ◯ No	If yes
Any other allergies?	◯ Yes ◯ No	If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Alzheimer's Disease/ Dementia ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Chemical Dependency ◯ Yes ◯ No
Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No
Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No
Shingles ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No	Asthma ◯ Yes ◯ No
Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No
Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No
Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No
Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Vertigo ◯ Yes ◯ No	Anxiety ◯ Yes ◯ No	Bi-Polar ◯ Yes ◯ No	

Do you have, or have you 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, Parent or Guardian:

X Date:_____