Mohr/ Henderson Medical History 8.14

Patient Name_____ Birth Date_____ Today's 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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Primary Care Physicians Name and Phone # _____
- Are you currently being treated by a Physician/Specialist? ○ Yes ○ No
- If yes, why _____

- Have you ever been hospitalized or had surgery? ○ Yes ○ No
- If yes, why and date_____

- Have you ever been diagnosed with cancer? ○ Yes ○ No
- If yes, type and date _____

- Have you ever had a serious head or neck injury? ○ Yes ○ No
- If yes, explain _____

- Are you taking any medications, pills or drugs? ○ Yes ○ No
- If yes, type and dosage _____

_____

_____

_____

- Are you taking any vitamins and/ or supplements? ○ Yes ○ No
- If yes, list type _____

- Do you require Pre-Medication? ○ Yes ○ No
- If yes, reason why _____

- Are you taking a Tricyclic Anti-Depressant? ○ Yes ○ No

- 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 Bisposphonates? ○ Yes ○ No

- Are you on a special diet? ○ Yes ○ No
- If yes, describe _____

- Do you use tobacco? ○ Yes ○ No
- If yes, type and how often _____
- Do you have a history of tobacco use? ○ Yes ○ No
- If yes, quit when? _____ yrs of use_____type _____ amount used _____

(Continued on Back)

Women: Are you….

☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

If pregnant, how many weeks and due date :_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other _____

Do you use a controlled substance? ○ Yes ○ No

If yes, type and how often _____

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

☐ AIDS/HIV+	☐ Cortisone Meds	☐ Hemophilia	☐ Radiation Treatment
☐ 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	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting /Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Diseas
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid 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	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease
☐ Yellow Jaundice	☐ Atrial Fibrillation	☐ Lyme Disease	☐ Sensory Concerns
☐ Autism	☐ Sleep Apnea	☐ Snoring	

Have you ever had any serious illness not listed above? ○ Yes ○ No _____

Additional 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 X _____ Date _____