MISSIH DENTAL CARE AND PERIODONTICS

NAME:_____ **DOB:**_____ **TODAY'S DATE:**_____

Are you under a physicians care? ☐ YES ☐ NO IF YES:_____

Have you ever had a major surgery or 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? ☐ YES ☐ NO IF YES: _____

Do you or have you taken: Phen- Fen, or Redux? ☐ YES ☐ NO IF YES: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? Y/N

PLEASE CHECK MARK ALL THAT APPLY:

Aids/HIV Positive ☐
Alzheimer's disease ☐
Anaphylaxis ☐
Anemia ☐
Angina ☐
Arthritis/Gout ☐
Artificial Joint ☐
Asthma ☐
Blood Disease ☐
Blood Transfusion ☐
Breathing Problems ☐
Bruise Easily ☐
Cancer ☐
Chemotherapy ☐
Chest Pains ☐
Cold Sores/Fevers ☐
Heart Disorder ☐
Convulsions ☐
Cortisone Medicine ☐
Diabetes ☐
Drug Addiction ☐
Easily Winded ☐
Emphysema ☐
Epilepsy or Seizures ☐
Excessive Bleeding ☐
Excessive thirst ☐
Fainting Spells/Dizziness ☐
Frequent Cough ☐
Frequent Diarrhea ☐
Frequent Headaches ☐
Genital Herpes ☐
Glaucoma ☐
Hay Fever ☐
Heart Attack/Failure ☐
Heart Murmur ☐
Heart Pacemaker ☐
Heart Trouble/Disease ☐
Hemophilia ☐
Hepatitis A ☐
Hepatitis B or C ☐
Herpes ☐
High Blood Pressure ☐
High Cholesterol ☐
Hives/Rash ☐
Hypoglycemia
Irregular Heartbeat ☐
Kidney Problems ☐
Leukemia ☐
Liver Disease ☐
Low Blood Pressure ☐
Lung Disease ☐
MitroValveProlapse ☐
Osteoporosis ☐
Pain in Jaw joints ☐
Parathyroid Disease ☐
Psychiatric care ☐
Radiation ☐
Recent Weight Loss ☐
Renal Dialysis ☐
Rheumatic Fever ☐
Rheumatism ☐
Scarlet Fever ☐
Shingles ☐
Sickle Cell Disease ☐
Sinus Trouble ☐
Spina Bifida ☐
Stomach/Intestinal disease ☐
Stroke ☐
Swelling Of limbs ☐
Thyroid Disease ☐
Tonsillitis ☐
Tuberculosis ☐
Tumors or Growths ☐
Ulcers ☐
Venereal Disease ☐
Yellow Jaundice ☐

Please list any allergies that you have: _____

Woman: Are you breastfeeding? Pregnant? Taking Oral Contraceptives? Circle all that apply.

I have answered all the questions on this form to the best of my knowledge. I understand that providing incorrect information can be dangerous to me or patient's health. It is my responsibility to inform the office of any changes in medical history.

☆ _____ _____

Signature of Patient or Guardian Date