3G Family Dentistry - Medical History

Patient's Full Name ____ Birth Date ______________________

Although dental professionals primarily treat areas in and around the mouth, the mouth is part of the entire body. Health problems and medications may have a vital interrelationship to the dentistry you will receive. Thank you for answering the following questions and keeping us updated of any changes.

	Yes	No	
Are you under the current care of a Physician?	☐	☐	Physician's name: ____________________
Physician's address: ____________________			Physician's Ph#: (____) ____________________
Are you taking any prescription medications or OTC medicines?	☐	☐	If yes, please provide list: ____________________
Have you ever been hospitalized or had a major surgery?	☐	☐	If yes, please specify: ____________________
Have you ever had a serious injury to your head, neck, or mouth?	☐	☐	If yes, please specify: ____________________
Have you been advised to take a PreMed before dental treatment?	☐	☐	If yes, please specify: ____________________
Have you ever taken Phen-Fen, Redux, Fosamax, Boniva, Actonel, or a medication containing bisphosphonates?	☐	☐	If yes, please specify: ____________________
Are you on a special diet?	☐	☐	If yes, please specify: ____________________
Do you use tobacco?	☐	☐	If yes, How often? ____________________
Do you drink alcohol?	☐	☐	If yes, How often? ____________________
Do you use controlled substances?	☐	☐	If yes, How often? ____________________

☐ Male

☐ Female

	Yes	No	
If female, are you pregnant, using birth control, trying to get pregnant, or breastfeeding?	☐	☐	If yes, please specify: ____________________

Are you allergic to any of the following? If YES, please specify type of allergic reaction : ☐ No Known Allergies

☐ Penicillin ______________	☐ Aspirin ______________	☐ Metals ______________	☐ Animals ______________
☐ Codeine ______________	☐ Local Anesthetics ______________	☐ Latex ______________	☐ Foods ______________
☐ Sulfa Drugs ______________	☐ Hay fever/Seasonal ______________	☐ Acrylic ______________	☐ Iodine ______________

☐ Other: ____

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

	Yes	No		Yes	No		Yes	No
Abnormal bleeding	☐	☐	Diabetes Type I or II	☐	☐	Mental health disorder	☐	☐
AIDS or HIV positive	☐	☐	Drug Addiction	☐	☐	Neurological disorder	☐	☐
Anemia	☐	☐	Eating disorder	☐	☐	Osteoporosis	☐	☐
Arteriosclerosis	☐	☐	Emphysema	☐	☐	Pacemaker	☐	☐
Arthritis/Gout	☐	☐	Endocarditis	☐	☐	Recent Weight loss/gain	☐	☐
Artificial joints	☐	☐	Epilepsy	☐	☐	Recurrent infection	☐	☐
Asthma	☐	☐	Excessive urination	☐	☐	Reflux/Persistent heartburn	☐	☐
Autoimmune disease	☐	☐	Fainting spells or Seizures	☐	☐	Rheumatic fever	☐	☐
Treated for Blood Pressure High/Low	☐	☐	Gastrointestinal problems	☐	☐	Rheumatic heart Disease	☐	☐
Blood transfusion	☐	☐	Glaucoma	☐	☐	Rheumatoid Arthritis	☐	☐
Bronchitis	☐	☐	Heart attack	☐	☐	Severe headaches/Migraines	☐	☐
Cancer, Chemo, or Radiation	☐	☐	Heart murmur	☐	☐	Sexually transmitted disease	☐	☐
Cardiovascular disease	☐	☐	Hepatitis/Jaundice/Liver disease	☐	☐	Sinus problems	☐	☐
Chest pain upon exertion	☐	☐	Irregular heartbeat	☐	☐	Sleep disorder	☐	☐
Treated for Cholesterol High/Low	☐	☐	Joint problems	☐	☐	Stroke	☐	☐
Chronic pain	☐	☐	Kidney problems	☐	☐	Thyroid Problems	☐	☐
Congestive Heart Failure	☐	☐	Lupus erythematosus	☐	☐	Tonsillitis	☐	☐
Damaged/Artificial heart valves	☐	☐	Lymphatic problems	☐	☐	Tuberculosis	☐	☐

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: ______________________

____

____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my, or the patient's, health. It is my resoponsibility to inform the dental office of any changes in medical status.

SIGNATURE of Patient, Parent, or Guardian ________________________________ Date ______________