Patient Name_____

MEDICAL HEALTH HISTORY

John W. Moore, DDS, SC
Kerrie A. Moore, DDS
Clara S. Ping, DDS
Andrea J. McNeely, DDS

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, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions. PLEASE PRINT.

Are you under a physician's care now? □ YES □ NO
Date of last physical? _____

Have you ever been hospitalized or had a major operation? □ YES □ NO
If yes, please list with approximate date:
_____
_____

Have you ever had a serious head or neck injury? If yes, explain. □ YES □ NO
_____
_____

Are you taking any medications, pills, or drugs? Please list. □ YES □ NO
_____
_____
_____
_____

Do you take, or have you ever taken, Phen-Fen or Redux? □ YES □ NO
_____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?
□ YES □ NO
_____

Are you on a special diet? If yes, please explain. □ YES □ NO
_____
_____

Do you use, or have you used, tobacco? □ YES □ NO
If yes, please explain/what kind? _____
Do you Pre-medicate prior to your dental appointment? Please explain. □ YES □ NO
_____
_____

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Over →

Women: Are you…

□ Pregnant/Trying to get Pregnant? □ Nursing? □ Taking Oral Contraceptives?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic

□ Metal □ Latex □ Sulfa Drugs □ Local Anesthetics

Do you use controlled substances? If yes, please explain. □ YES □ NO

_____

_____

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

AIDS/HIV	☐ YES	Epilepsy/Seizures	☐ YES	Liver Disease	☐ YES
Alzheimer's Disease	☐ YES	Excessive Bleeding	☐ YES	Swelling of Limbs	☐ YES
Anaphylaxis	☐ YES	Excessive Thirst	☐ YES	Thyroid Disease	☐ YES
Anemia	☐ YES	Fainting Spells/Dizziness	☐ YES	Tumors or Growths	☐ YES
Angina	☐ YES	Frequent Cough	☐ YES	Ulcers	☐ YES
Anxiety	☐ YES	Frequent Diarrhea	☐ YES	Venereal Disease	☐ YES
Arthritis/Gout	☐ YES	Frequent Headaches	☐ YES	Radiation Treatments	☐ YES
Artificial Heart Valve	☐ YES	Low Blood Pressure	☐ YES	Recent Weight Loss	☐ YES
Artificial Joint	☐ YES	Lung Disease	☐ YES	Renal Dialysis	☐ YES
Asthma	☐ YES	Mitral Valve Prolapse	☐ YES	Rheumatic Fever	☐ YES
Blood Disease	☐ YES	Osteoporosis	☐ YES	Rheumatism	☐ YES
Blood Transfusion	☐ YES	Pain in Jaw Joints	☐ YES	Scarlet Fever	☐ YES
Breathing Problems	☐ YES	Parathyroid Disease	☐ YES	Shingles	☐ YES
Bruise Easily	☐ YES	Psychiatric Care	☐ YES	Sickle Cell Disease	☐ YES
Glaucoma	☐ YES	Hemophilia	☐ YES	Sinus Trouble	☐ YES
Hay Fever	☐ YES	Hepatitis A	☐ YES	Spina Bifida	☐ YES
Heart Attack/Failure	☐ YES	Hepatitis B or C	☐ YES	Stomach Disease	☐ YES
Heart Murmur	☐ YES	Herpes	☐ YES	Stroke	☐ YES
Heart Pacemaker	☐ YES	High Blood Pressure	☐ YES	Cancer	☐ YES
Heart Trouble/Disease	☐ YES	High Cholesterol	☐ YES	Chemotherapy	☐ YES
Cortisone Medicine	☐ YES	Hives or Rash	☐ YES	Chest Pains	☐ YES
Diabetes	☐ YES	Hypoglycemia	☐ YES	Cold Sores/Blisters	☐ YES
Drug Addiction	☐ YES	Irregular Heartbeat	☐ YES	Cong. Heart Disorder	☐ YES
Easily Winded	☐ YES	Kidney Problems	☐ YES	Convulsions	☐ YES
Emphysema	☐ YES	Leukemia	☐ YES	Yellow Jaundice	☐ YES

Have you ever had any serious illness not listed? If yes, please explain. □ YES □ NO

_____

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 health. It is my responsibility to inform the dental office of any changes in medical status. I acknowledge that my signature will be kept on file for further updates to my health history.

X Date:

Please ensure this information is correct