

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. 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

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

Do you take Fluoride supplements? YES

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

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