Esthetic Design Dental

Medical History

Patient Name: _____ Date of Birth: _____

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy which is available upon request.

Are you under a physician's care?	Yes ☐ No ☐	If Yes, please explain: _____
Have you ever been hospitalized?	Yes ☐ No ☐	If Yes, please explain: _____
Have you ever had a major operation?	Yes ☐ No ☐	If Yes, please explain: _____
Have you ever had a serious head/neck injury?	Yes ☐ No ☐	If Yes, please explain: _____
Are you taking any medications?	Yes ☐ No ☐	If Yes, please explain: _____
Do you take or taken Phen-Fen?	Yes ☐ No ☐	If Yes, please explain: _____
Do you take or taken Fosamax, Boniva, Actonel?	Yes ☐ No ☐	If Yes, please explain: _____
Are you on a special diet?	Yes ☐ No ☐	If Yes, please explain: _____
Do you use tobacco?	Yes ☐ No ☐	
Do you use controlled substances?	Yes ☐ No ☐	

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

AIDS/HIV Positive	Yes ☐ No ☐	Cortisone Medicine	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐	Recent Weight Loss	Yes ☐ No ☐
Alzheimer's	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Hepatitis A	Yes ☐ No ☐	Renal Dialysis	Yes ☐ No ☐
Anaphylaxis	Yes ☐ No ☐	Drug Addiction	Yes ☐ No ☐	Hepatitis B or C	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Easily Winded	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Rheumatism	Yes ☐ No ☐
Angina	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	High Cholesterol	Yes ☐ No ☐	Scarlet Fever	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐	Hives or Rash	Yes ☐ No ☐	Shingles	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐	Excessive Bleeding	Yes ☐ No ☐	Hypoglycemia	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐	Excessive Thirst	Yes ☐ No ☐	Irregular Heart Beat	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Fainting Spells	Yes ☐ No ☐	Kidney Problems	Yes ☐ No ☐	Spina Bifida	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐	Frequent Cough	Yes ☐ No ☐	Leukemia	Yes ☐ No ☐	Stomach Disease	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Frequent Diarrhea	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Swelling of Limbs	Yes ☐ No ☐
Breathing Trouble	Yes ☐ No ☐	Frequent Headaches	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐	Thyroid Disease	Yes ☐ No ☐
Bruise Easily	Yes ☐ No ☐	Genital Herpes	Yes ☐ No ☐	Lung Disease	Yes ☐ No ☐	Tonsillitis	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐	TB (Tuberculosis)	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Hay Fever	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐	Tumors	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Heart Attack	Yes ☐ No ☐	Pain in Jaw Joints	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Cold Sores/Fever Blisters	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Parathyroid	Yes ☐ No ☐	Venereal Diseases	Yes ☐ No ☐
Congenital Heart Disorder	Yes ☐ No ☐	Heart Pacemaker	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐	Yellow Fever	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐	Radiation Treatment	Yes ☐ No ☐		Yes ☐ No ☐

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

Additional Information: _____

Women: Are you

Pregnant/Trying to get pregnant? Yes ☐ No ☐ Taking oral contraceptive? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthesia ☐ Acrylic ☐ Metal ☐ Latex ☐

Sulfa Drugs ☐ Others ☐ If yes, please explain _____

The questions on the form has been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patients) health. I also understand it is my responsibility to inform dental office of any changes to the medical status.

Signature of Patient, Parent (or Guardian): _____ Date: _____