Barry Family Dentistry Medical History Form 2018

Patient Name: Birth Date: Date Created:

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, c

Is there currently a problem for which you are seeing a physician?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics
Other_____			

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Medications

Please list any medications you are currently taking:

1._____ 9._____
2._____ 10._____
3._____ 11._____
4._____ 12._____
5._____ 13._____
6._____ 14._____
7._____ 15._____
8._____ 16._____

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Anaphylaxis	Yes No
Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No
Herpes	Yes No	Rheumatic Fever	Yes No	Angina	Yes No	Emphysema	Yes No
High Blood Pressure	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No
Scarlet Fever	Yes No	Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No
Shingles	Yes No	Artificial Joint	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Kidney Problems	Yes No	Blood Transfusion	Yes No	Leukemia	Yes No
Stomach/Intestinal Disease	Yes No	Breathing Problems	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Cancer	Yes No
Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No	Hay Fever	Yes No
Mitral Valve Prolapse	Yes No	Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No
Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No
Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____