Barry Family Dentistry Medical History Form 2020(Copy)

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

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you taking blood thinners?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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

Other? ☐ If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Emphysemia	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Hemophilia	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Herpes	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No						

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

Medications Currently Taking:

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:_____