Saint Peter Family Dental Center

Date 5/22/2014

St Peter Family Dental Center Medical History

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
Has a medical doctor recommended an antibiotic (premedication) before having dental treatment?	Yes No	If yes
Are you taking any blood thinners?	Yes No	If yes
Have you ever been treated for bone cancer or osteoporosis?	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 in any form?	Yes No	

Women: Are you...

- Pregnant/possibly pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Penicillin
- Acrylic
- Aspirin
- Codeine
- Latex
- Local Anesthetics
- Metal
- Sulfa Drugs

Other Allergies? Yes No If yes

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

Heart Attack/Failure	Yes No	Excessive Bleeding	Yes No	Anaphylaxis	Yes No	AIDS/HIV Positive	Yes No
Heart Disease/Trouble	Yes No	Blood Disease	Yes No	Arthritis	Yes No	Hepatitis (List type in comments)	Yes No
Stroke	Yes No	Psychiatric Care	Yes No	Artificial Joint	Yes No	Cold Sores/Fever Blisters	Yes No
Chest Pains/Angina	Yes No	Alzheimer's Disease	Yes No	Bruise Easily	Yes No	Rheumatic Fever	Yes No
High Blood Pressure	Yes No	Drug Addiction	Yes No	Osteoporosis	Yes No	Scarlet Fever	Yes No
Low Blood Pressure	Yes No	Epilepsy or Seizures	Yes No	Pain in Jaw Joints	Yes No	Tuberculosis	Yes No
Artificial Heart Valve	Yes No	Frequent Headaches	Yes No	Cancer	Yes No	Asthma	Yes No
Mitral Valve Prolapse	Yes No	Convulsions	Yes No	Chemotherapy	Yes No	Sinus Trouble	Yes No
Heart Pace Maker	Yes No	Thyroid Disease	Yes No	Radiation	Yes No	Breathing Problems	Yes No
Irregular Heartbeat	Yes No	Parathyroid Disease	Yes No	Kidney Problems/Dialysis	Yes No	Emphysema	Yes No
Sickle Cell Disease	Yes No	Diabetes	Yes No	Liver Disease	Yes No	Lung Disease	Yes No
Hemophelia	Yes No	Excessive Thirst	Yes No	Eating Disorder (Past or Present)	Yes No	Stomach/Intestinal Disorder	Yes No

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

Please list any medications, supplements, or controlled substances that you take on a regular basis

Comments

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: