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Mini Dental Implant Centers of America

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

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. Thanks you for answering the following questions.

1. PLEASE CHECK YES OR NO:

Are you under physicians care now? ☐ YES or ☐ NO If yes, please explain_____

Have you ever been hospitalized or had a major operation? ☐ YES or ☐ NO If yes, please explain_____

Have you ever had a serious head or neck injury? ☐ YES or ☐ NO If yes, please explain_____

Are you taking any medications, pills or drugs? ☐ YES or ☐ NO If yes, please explain_____

Do you take or have you taken Phen-Fen or Redux? ☐ YES or ☐ NO If yes, please explain_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES or ☐ NO If yes, please explain_____

Are you on special diet? ☐ YES or ☐ NO If yes, please explain_____

Do you use tobacco? ☐ YES or ☐ NO If yes, please explain (HOW MANY CIGARETTES PER DAY) _____

Do you use controlled substances? ☐ YES or ☐ NO If yes, please explain_____

2. WOMEN:

Are you Pregnant/Trying to get pregnant? ☐ YES or ☐ NO Taking Oral Contraceptives? ☐ YES or ☐ NO Nursing? ☐ YES or ☐ NO

3. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa

OTHERS If yes, explain_____

4. 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	Recent Weight Loss	☐ YES ☐ NO
Anaphylaxis	☐ YES ☐ NO	Drug Addiction	☐ YES ☐ NO	Hepatitis B or C	☐ YES ☐ NO	Renal Dialysis	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Easily Winded	☐ YES ☐ NO	Herpes	☐ YES ☐ NO	Rheumatism	☐ YES ☐ NO
Angina	☐ YES ☐ NO	Emphysema	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Arthritis/Gout	☐ YES ☐ NO	Epilepsy or Seizures	☐ YES ☐ NO	High Cholesterol	☐ YES ☐ NO	Shingles	☐ YES ☐ NO
Artificial Heart Valve	☐ YES ☐ NO	Excessive Bleeding	☐ YES ☐ NO	Hives or Rash	☐ YES ☐ NO	Sickle Cell Disease	☐ YES ☐ NO
Artificial Joint	☐ YES ☐ NO	Excessive Thirst	☐ YES ☐ NO	Hypoglycemia	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Fainting Spells/Dizziness	☐ YES ☐ NO	Irregular Heartbeat	☐ YES ☐ NO	Spine Bifida	☐ YES ☐ NO
Blood Disease	☐ YES ☐ NO	Frequent Cough	☐ YES ☐ NO	Kidney Problems	☐ YES ☐ NO	Stomach/Intestinal Disease	☐ YES ☐ NO
Blood Transfusion	☐ YES ☐ NO	Frequent Diarrhea	☐ YES ☐ NO	Leukemia	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Breathing Problem	☐ YES ☐ NO	Frequent Headaches	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Swelling of Limbs	☐ YES ☐ NO
Bruise Easily	☐ YES ☐ NO	Genital Herpes	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Lung Disease	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Hay fever	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Chest Pains	☐ YES ☐ NO	Heart Attack/Failure	☐ YES ☐ NO	Osteoporosis	☐ YES ☐ NO	Tumors Growths	☐ YES ☐ NO
Cold Sores/Fever Blisters	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Pain in Jaw Joints	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Congenital Heart Disorder	☐ YES ☐ NO	Heart Pacemaker	☐ YES ☐ NO	Parathyroid Disease	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Convulsions	☐ YES ☐ NO	Heart Trouble/Disease	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO	Yellow Jaundice	☐ YES ☐ NO

5. HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ YES or ☐ NO

If YES, please explain: _____

_____

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 responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____