Beaufort Family Dentistry

Medical History Form

Thank you for choosing Beaufort Family Dentistry! Please take a few minutes to fill out these forms to help us get to know you!

Patient's Name: _____ Date of Birth: ____/ ____/ ____ Today's Date: ____/ ____/ ____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 had a serious head or neck injury?	☐ Yes	☐ No	If yes _____
Are you taking any medications, pills or drugs? Provide List.	☐ Yes	☐ No	If yes _____
Did you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphophonates?	☐ Yes	☐ No	If yes _____
Are you on a special diet?	☐ Yes	☐ No	If yes _____
Do you use tobacco?	☐ Yes	☐ No	If yes _____

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Local Anesthetics
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Other? If yes _____	

Do you use controlled substances?

☐ Yes ☐ No If yes _____

Please check any of the following conditions that apply to you:

☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Alzeimer's Disease	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Anaphylaxis	☐ Convulsions	☐ Heart Attach/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Anemia	☐ Cortisone Medication	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Angina	☐ Diabetes	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Arthritis/Gout	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Osteoporosis	☐ Swelling of Limbs
☐ Artificial Heart Valve	☐ Easily Winded	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Artificial Joint	☐ Emphysema	☐ Hepatitis A	☐ Parathyroid Disease	☐ Tonsilitis
☐ Asthma	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tuberculosis
☐ Blood Disease	☐ Excessive Bleeding	☐ Herpes	☐ Radiation Treatments	☐ Tumors or Growths
☐ Blood Transfusion	☐ Excessive Thirst	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Ulcers
☐ Breathing Problems	☐ Fainting Spells/Dizziness	☐ High Cholesterol	☐ Renal Dialysis	☐ Venereal Diseases
☐ Bruise Easily	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Yellow Jaundice
☐ Cancer	☐ Frequent Diarrhea	☐ Hypoglocemia	☐ Rheumatism	
☐ Chemotherapy	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever	
☐ Chest Pain	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles	

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

Comments: _____

_____

Consent: *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.*

_____ _____

Patient Signature *(parent if minor)* **Date**