Loudoun Dental Associates

**MEDICAL HISTORY**

PATIENT NAME Birth Date

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, please explain:

Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs?

Do you take, or have you taken, Phen-Fen or Redux?

Have you ever taken Fosamax, Boniva, Actonel or any

Yes No If yes, please explain: Yes No If yes, please explain: Yes No If yes, please explain: Yes No

other medications containing bisphosphonates? Yes No

Are you on a special diet? Yes No Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you

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

Are you allergic to any of the following?

Aspirin Penicillin Codeine

Local Anesthetics

Acrylic

Metal

Latex

Sulfa drugs

Other If yes, please explain:

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

AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia 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 Anemia Yes No Easily Winded Yes No Herpes 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 Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Breathing Problem Yes No Frequent Headaches Yes No Liver Disease Yes No Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Cancer Yes No Glaucoma Yes No Lung 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 Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints 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

Radiation Treatments

Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles

Sickle Cell Disease Sinus Trouble Spina Bifida

Stomach/Intestinal Disease Stroke

Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers

Venereal Disease Yellow Jaundice

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

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

Comments:

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE