Dr. Lori Trembath, DDS, PC
Family Dentistry

MEDICAL HISTORY FORM

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?	☐ Yes ☐ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes, please explain: _____
Do you take, or have taken, Phen-Fen or Redux?	☐ Yes ☐ No	_____
Have you ever taken Fosamax, Boniva, Actenol or any 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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs
☐ Other If yes, please explain: _____

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

AIDS/ HIV Positive	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Fainting Spells/ Dizziness	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Arhtirits/ Gout	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Artifical Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Attack/ Failure	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Trouble/ Disease	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Cold Sores/ Fever Blisters	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stomach/ Intestinal Disease	☐ Yes ☐ No
Congentital Heart Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Epipsy or Seizures	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Veneral Disease	☐ Yes ☐ No
		Low Blood Pressure	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments and Signature

_____

_____

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: _____