MEDICAL HISTORY FORM

Logan Peak Dental

Patient Name _____Birthdate _____ Gender: ☐ Male ☐ Female Age _____

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 currently under a physician's care?	☐ Yes ☐ No	Condition:
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If Yes, Explain:
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	
Do you take, or have you taken, Phen Fen or Redux?	☐ Yes ☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If Yes when?
Are you on a diet or special diet?	☐ Yes ☐ No	
Do you use tobacco? If Yes, Amount per day _____	☐ Yes ☐ No	☐ Cigarettes ☐ Smokeless
Do you use controlled substances?	☐ Yes ☐ No	
Are you currently taking any med's, OTC pills, diet pills, or drugs?	☐ Yes ☐ No	If Yes, Explain:
Have you ever been advised to pre-med for dental procedures?	☐ Yes ☐ No	If Yes, Medication:
Are you pregnant or trying to get pregnant?	☐ Yes ☐ No	If applicable, Due Date_____
Are you currently nursing?	☐ Yes ☐ No	
Are you currently taking any oral contraceptives?	☐ Yes ☐ No	

Are you allergic to any of the following?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Metal ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other _____

Are you subject to Anaphylaxis? ☐ Yes ☐ No

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

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

Have you ever had any serious illness, disorder, or condition not listed above? ☐ Yes ☐ No

Additional 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 : _____ Date: _____

(Parent/Guardian must sign for patient 17 years old and younger)

LOGAN PEAK DENTAL

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