Corwin Family Dentistry
Medical History

Patient Name:_____ Birthdate:_____

Although Dental personnel treat the area in and around your mouth, you mouth is a part of your entire body. Please inform us of any health problems you may have or medication you are taking.

Are you under the care of a physician right now? Y/N If yes_____

Have you ever been hospitalized or had a major operation? Y/N If yes_____

Have you ever had a serious head or neck injury? Y/N If yes_____

Are you taking any medications, pills, or drugs? Y/N If yes_____

_____

Do you take, or have you taken, Phen-Fen or Redux? Y/N If yes_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y/N If yes_____

Are you on a special diet? Y/N

Do you use tobacco? Y/N

Women: Are you.....

☐ Pregnant/Trying to get pregnant ☐ Nursing? ☐ Taking Oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillian ☐ Codeine ☐Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? Y/N If yes_____

Do you use Controlled Substances Y/N If yes_____

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

AIDS/HIV Y/N	Cortisone Medicine Y/N	Hemophilia Y/N	Radiation Treatment Y/N
Alzheimer's Y/N	Diabetes Y/N	Hepatitis A Y/N	Recent Weight Loss Y/N
Anaphylaxis Y/N	Drug Addiction Y/N	Hepatitis B or C Y/N	Renal Dyalysis Y/N
Anemia Y/N	Easily Winded Y/N	Herpes Y/N	Rheumatic Fever Y/N
Angina Y/N	Emphysema Y/N	High Blood Pressure Y/N	Rheumatism Y/N
Arthritis/Gout Y/N	Epilepsy or Seizures Y/N	High Cholesterol Y/N	Scarlet Fever Y/N
Artificial Heart Valve Y/N	Excessive Bleeding Y/N	Hives or Rash Y/N	Shingles Y/N
Artificial Joint Y/N	Excessive Thirst Y/N	Hypoglycemia Y/N	Sickle Cell Disease Y/N
Asthma Y/N	Fainting Spells/Dizziness Y/N	Irregular Heartbeat Y/N	Sinus Trouble Y/N
Blood Disease Y/N	Frequent Cough Y/N	Kidney Problems Y/N	Spina Bifida Y/N
Blood Transfusion Y/N	Frequent Diarrhea Y/N	Leukemia Y/N	Stomach/Intestinal Disease Y/N
Breathing Problems Y/N	Frequent Headaches Y/N	Liver Disease Y/N	Stroke Y/N

Bruise Easily Y/N	Genital Herpes Y/N	Low Blood Pressure Y/N	Swelling of Limbs Y/N
Cancer Y/N	Glaucoma Y/N	Lung Disease Y/N	Thyroid Disease Y/N
Chemotherapy Y/N	Hay Fever Y/N	Mitral Valve Prolapse Y/N	Tonsillitis Y/N
Chest Pains Y/N	Heart Attack/Failure Y/N	Osteoporosis Y/N	Tuberculosis Y/N
Cold Sores/Fever Blister Y/N	Heart Murmur Y/N	Pain in Jaw Joints Y/N	Tumors/Growths Y/N
Congenital heart Disorder Y/N	Heart Pacemaker Y/N	Parathyroid Disease Y/N	Ulcers Y/N
Convulsions Y/N	Heart Trouble/Disease Y/N	Psychiatric Care Y/N	Venereal Disease Y/N
			Yellow Jaundice Y/N

Have you ever had any serious illness not listed? Y/N

Comments:_____

_____

Signaure:_____ Date:_____