Bowen Family Dentistry - Medical/Dental History

Patient Name: Birth Date: Date Created:

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? If yes, please provide name and phone number.	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major surgery? If yes, when?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury? If yes, when?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs? If yes, please list.	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux? If yes, how recent?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet? What type?	◯ Yes ◯ No	If yes	
Do you currently or in the past used tobacco? If yes, what type?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

☐ How many months:_____

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other Known Allergies? If yes, please explain.	◯ Yes ◯ No	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	

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

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

Have you ever had any serious illness not listed above? If yes, please explain. ◯ Yes ◯ No If yes

Additional Comments or Concerns:

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:

X Date:_____