TRANSFORMATION
DENTAL PARTNERS

MEDICAL HISTORY

PATIENT NAME: _____

Are you under a physician's care now? ☐ Yes ☐ No If yes_____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes_____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes_____
Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No If yes_____
Do you or have you taken Fosamax, Boniva or any Bisphosphonate? ☐ Yes ☐ No If yes_____

Please list all the medications you are currently taking. **Include the dosage, how often and reason.**

_____

Do you use:
☐ Tobacco ☐ Controlled substances

Women: Are you
☐ Pregnant / Trying to get pregnant? ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following:
☐ Aspirin ☐ Penicillin ☐ Latex ☐ Local Anesthetics
☐ Codeine ☐ Metal ☐ Sulfa Drugs ☐ Other: _____

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

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

The information above is current and accurate. I have listed all medications I am currently taking and listed all products that I am allergic to. I understand that it is my responsibility to notify the office of any changes in intake or allergies.

Patient Signature: _____ Date _____

Parent or Responsible Party: _____ Relationship to the Patient: _____

FOR OFFICE USE: Reviewed by Dr._____ Date _____

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