

MEDICAL STATUS FORM

Name: _____

Birth date _____

Address: _____

Sex ___M ___F

Phones: home: _____

work: _____

email: _____

cell: _____

The dentistry you receive has an important interrelationship with the health problems that you may have, or medications you are taking. It is imperative that you provide the following information to help us treat you as effectively and safely as possible.

Please initial that you read this paragraph: _____

Are you under a physician's care now?	()yes ()no	If yes, please explain: Dr. Name: Address: Telephone Number: Date of last physical exam:
Have you ever been hospitalized or had a major operation in the past five years?	()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 prescription or non-prescription medications, pills, herbal supplements, aspirin, ibuprophen, vitamin E or drugs?	()yes ()no	If yes, please list and explain: _____ _____
Are you taking or have you taken bisphosphonate for osteoporosis: such as Actonel, Boniva, Fosamax, Zometa or Aredia?	()yes ()no	If yes, please explain:
Have you ever been advised to take pre-medication for dental visits?	()yes ()no	If yes, please explain:
Have you ever had a lesion biopsied or removed from the mouth or lips?	()yes ()no	If yes, please explain:
Are you on a special diet?	()yes ()no	If yes, please explain:
Do you smoke or use tobacco?	()yes ()no	If yes, how much? How long?
Do you use controlled substances?	()yes ()no	If yes, please explain:
Do you consume alcohol?	()yes ()no	If yes, please explain:
Has anyone told you that you snore?	()yes ()no	

WOMEN:	Are you pregnant or trying to get pregnant?	() Yes	() No
	Taking oral contraceptives?	() Yes	() No
	Nursing?	() Yes	() No

DA/RDH Initials: _____

Dr. Initials: _____

Are you allergic to any of the following:

- Aspirin Penicillin Tetracycline Erythromycin Codeine
 Acrylic Metal Sulfa Local Anesthetics Latex
 Other: _____ No Known Allergies

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

AIDS/HIV Positive	<input type="checkbox"/> yes <input type="checkbox"/> no	Implants-Hip/Breast/knee/tooth	<input type="checkbox"/> yes <input type="checkbox"/> no
Allergies	<input type="checkbox"/> yes <input type="checkbox"/> no	HPV (Human Papilloma Virus)	<input type="checkbox"/> yes <input type="checkbox"/> no
Alzheimer's Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no
Anaphylaxis	<input type="checkbox"/> yes <input type="checkbox"/> no	Hives or Rash	<input type="checkbox"/> yes <input type="checkbox"/> no
Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	Hypoglycemia	<input type="checkbox"/> yes <input type="checkbox"/> no
Angina/Chest Pains	<input type="checkbox"/> yes <input type="checkbox"/> no	Irregular Heartbeat	<input type="checkbox"/> yes <input type="checkbox"/> no
Arthritis/Gout	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney Problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Artificial Heart Valve	<input type="checkbox"/> yes <input type="checkbox"/> no	Leukemia	<input type="checkbox"/> yes <input type="checkbox"/> no
Artificial Joint	<input type="checkbox"/> yes <input type="checkbox"/> no	Liver Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Low Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no
Blood Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Lung Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Blood Transfusion	<input type="checkbox"/> yes <input type="checkbox"/> no	Mitral Valve Prolapse	<input type="checkbox"/> yes <input type="checkbox"/> no
Bruise Easily	<input type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	Periodontal "gum" Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Chemotherapy	<input type="checkbox"/> yes <input type="checkbox"/> no	Psychiatric Care	<input type="checkbox"/> yes <input type="checkbox"/> no
Celiac Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Radiation Treatments	<input type="checkbox"/> yes <input type="checkbox"/> no
Congenital Heart Disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	Recent Weight Loss	<input type="checkbox"/> yes <input type="checkbox"/> no
Convulsions	<input type="checkbox"/> yes <input type="checkbox"/> no	Renal Dialysis	<input type="checkbox"/> yes <input type="checkbox"/> no
Cortisone Medicine	<input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatic Fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatism	<input type="checkbox"/> yes <input type="checkbox"/> no
Drug Addiction	<input type="checkbox"/> yes <input type="checkbox"/> no	Scarlet Fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Eating Disorder (Bulimia and/or Anorexia)	<input type="checkbox"/> yes <input type="checkbox"/> no	Stomach/Intestinal Disease/Ulcers	<input type="checkbox"/> yes <input type="checkbox"/> no
Emphysema	<input type="checkbox"/> yes <input type="checkbox"/> no	Shortness of Breath	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy or Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no	Sickle Cell Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Excessive Bleeding	<input type="checkbox"/> yes <input type="checkbox"/> no	Sinus Trouble	<input type="checkbox"/> yes <input type="checkbox"/> no
Excessive Thirst	<input type="checkbox"/> yes <input type="checkbox"/> no	Special Diet	<input type="checkbox"/> yes <input type="checkbox"/> no
Fainting Spells/Dizziness	<input type="checkbox"/> yes <input type="checkbox"/> no	Spina Bifida	<input type="checkbox"/> yes <input type="checkbox"/> no
Frequent Cough	<input type="checkbox"/> yes <input type="checkbox"/> no	Shingles/Herpes/Cold sores/Fever blisters	<input type="checkbox"/> yes <input type="checkbox"/> no
Frequent Diarrhea	<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no
Frequent Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	Swelling of Limbs	<input type="checkbox"/> yes <input type="checkbox"/> no
Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid Condition	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Attack/Failure	<input type="checkbox"/> yes <input type="checkbox"/> no	Tonsilitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Murmur	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Pace Maker	<input type="checkbox"/> yes <input type="checkbox"/> no	Tumors or Growths	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Trouble/Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Venereal Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Hemophilia	<input type="checkbox"/> yes <input type="checkbox"/> no	Yellow Jaundice	<input type="checkbox"/> yes <input type="checkbox"/> no
Hepatitis A, B, C, D, or E	<input type="checkbox"/> yes <input type="checkbox"/> no	Contact Lenses	<input type="checkbox"/> yes <input type="checkbox"/> no

Have you ever had any serious illness not listed above? () Yes () No

If yes, please explain: _____

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 _____

DA/RDH Initials: _____

Dr. Initials: _____