**Brier Creek Smiles Dentistry
Medical History**

 Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_
 Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Dental Insurance: Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? **□**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 medications, pills, or drugs? **□**Yes **□**No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? **□**Yes **□**No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you ever taken Fosamax, Boniva, Actonel or any
other medications containing bisphosphonates? **□**Yes **□**No
Are you on a special diet? **□**Yes **□**No
Do you use tobacco? **□**Yes **□**No
Do you use controlled substances? **□**Yes **□**No

**Women: Are you?**

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? **□**Yes **□**No Nursing? **□**Yes **□**No

**Are you allergic to any of the following?**

**□**Aspirin **□**Penicillin **□**Codiene **□**Local Anesthetics **□**Acrylic **□**Metal **□**Latex **□**Sulfa Drugs
**□**Other If yes, Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ n:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
| AIDS/HIV Positive **□**Yes **□**NoAlzheimer's Disease **□**Yes **□**NoAnaphylaxis **□**Yes **□**NoAnemia **□**Yes **□**NoAngina **□**Yes **□**NoArthritis/Gout **□**Yes **□**NoArtificial Heart Valve **□**Yes **□**NoArtificial Joint **□**Yes **□**NoAsthma **□**Yes **□**NoBlood Disease **□**Yes **□**NoBlood Transfusion **□**Yes **□**NoBreathing Problem **□**Yes **□**NoBruise Easily **□**Yes **□**NoCancer **□**Yes **□**NoChemotherapy **□**Yes **□**NoChest Pains **□**Yes **□**NoCold Sores/Fever Blisters **□**Yes **□**NoCongenital Heart Disorder **□**Yes **□**NoConvulsions **□**Yes **□**No | Cortisone Medicine **□**Yes **□**NoDiabetes **□**Yes **□**NoDrug Addiction **□**Yes **□**NoEasily Winded **□**Yes **□**NoEmphysema **□**Yes **□**NoEpilepsy/Seizures **□**Yes **□**NoExcessive Bleeding **□**Yes **□**NoExcessive Thirst **□**Yes **□**NoFainting/Dizziness **□**Yes **□**NoFrequent Cough **□**Yes **□**NoFrequent Diarrhea **□**Yes **□**NoFrequent Headaches **□**Yes **□**NoGenital Herpes **□**Yes **□**NoGlaucoma **□**Yes **□**NoHay Fever **□**Yes **□**NoHeart Attack/Failure **□**Yes **□**NoHeart Murmur **□**Yes **□**NoHeart Trouble/Disease **□**Yes **□**NoHeart Pacemaker **□**Yes **□**No | Hemophilia **□**Yes **□**NoHepatitis A **□**Yes **□**NoHepatitis B or C **□**Yes **□**NoHerpes **□**Yes **□**NoHigh Blood Pressure **□**Yes **□**NoHigh Cholesterol **□**Yes **□**NoHives/Rash **□**Yes **□**NoHypoglycemia **□**Yes **□**NoIrregular Heartbeat **□**Yes **□**NoKidney Problems **□**Yes **□**NoLeukemia **□**Yes **□**NoLiver Disease **□**Yes **□**NoLow Blood Pressure **□**Yes **□**NoLung Disease **□**Yes **□**NoMitral Valve Prolapse **□**Yes **□**NoOsteoporosis **□**Yes **□**NoPain in Jaw/Joints **□**Yes **□**NoParathyroid Disease **□**Yes **□**NoPsychiatric Care **□**Yes **□**No | Radiation Treatment **□**Yes **□**NoRecent Weight Loss **□**Yes **□**NoRenal Dialysis **□**Yes **□**NoRheumatic Fever **□**Yes **□**NoRheumatism **□**Yes **□**NoScarlet Fever **□**Yes **□**NoShingles **□**Yes **□**NoSickle Cell Disease **□**Yes **□**NoSinus Trouble **□**Yes **□**NoSpina Bifida **□**Yes **□**NoStomach/Intestinal **□**Yes **□**NoDiseaseStroke **□**Yes **□**NoSwelling of Limbs **□**Yes **□**NoThyroid Disease **□**Yes **□**NoTonsillitis **□**Yes **□**NoTuberculosis **□**Yes **□**NoTumors or Growths **□**Yes **□**NoUlcers **□**Yes **□**NoVenereal Disease **□**Yes **□**No |

**Have you ever had a serious illness not listed?** **□**Yes **□**No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Brier Creek Smiles Dentistry of any changes in medical status.

SIGNATURE OF PATIENT/PARENT/GUARDIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_