**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 **□**No  Alzheimer's Disease **□**Yes **□**No  Anaphylaxis **□**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  Blood Transfusion **□**Yes **□**No  Breathing Problem **□**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/Seizures **□**Yes **□**No  Excessive Bleeding **□**Yes **□**No  Excessive Thirst **□**Yes **□**No  Fainting/Dizziness **□**Yes **□**No  Frequent Cough **□**Yes **□**No  Frequent Diarrhea **□**Yes **□**No  Frequent Headaches **□**Yes **□**No  Genital Herpes **□**Yes **□**No  Glaucoma **□**Yes **□**No  Hay Fever **□**Yes **□**No  Heart Attack/Failure **□**Yes **□**No  Heart Murmur **□**Yes **□**No  Heart Trouble/Disease **□**Yes **□**No  Heart Pacemaker **□**Yes **□**No | Hemophilia **□**Yes **□**No  Hepatitis A **□**Yes **□**No  Hepatitis B or C **□**Yes **□**No  Herpes **□**Yes **□**No  High Blood Pressure **□**Yes **□**No  High Cholesterol **□**Yes **□**No  Hives/Rash **□**Yes **□**No  Hypoglycemia **□**Yes **□**No  Irregular Heartbeat **□**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 Treatment **□**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 **□**Yes **□**No  Disease  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  Venereal 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_