ITC Dental
Implant Center & General Dentistry

MEDICAL HISTORY

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 medications 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 been hospitalized or had a major operation?	☐ 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	
Have you ever taken Fosamax, Bovina, 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	

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs
☐ Other, if yes please explain: _____ _____
☐ None or None known

Women:
☐ Pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

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

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

Have you had any other serious illness not mentioned above? _____

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 or prescription drugs taken.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ DATE _____

SIGNATURE OF DOCTOR _____

PATIENT NAME: _____ BIRTH DATE: _____