Danville Dental Group Patient Medical History Form (February 2017)

Patient Name: Birth Date: Date Created:

Question	Answer	
Do you have a primary care physician? Please name	◯ 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
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Medications

Question	Answer	
Are you taking any medications? Please list in the box below.	◯ Yes ◯ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
*DO YOU REQUIRE PRE-MEDICATION?	◯ Yes ◯ No	

Pharmacy Information

Question	Answer	
Do you use a local Pharmacy? Please list with Town and/or Phone Number:	◯ Yes ◯ No	If yes

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine
☐ Acrylic	☐ Metal	☐ Latex
☐ Sulfa Drugs	☐ Local Anesthetics	

Question	Answer	
Other Allergies	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Angina	◯ Yes ◯ No	High Blood Pressur	◯ Yes ◯ No
Epilepsy or Seizure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Low Blood Pressur	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No

Question	Answer	
Do you, or have you had any Heart Disease? Please explain:	◯ Yes ◯ No	If yes
Do you, or have you had any Lung Disease? Please explain:	◯ Yes ◯ No	If yes
Do you,or have you had any Kidney Disease? Please explain:	◯ Yes ◯ No	If yes
Do you, or have you had any Blood Disease? Please explain:	◯ Yes ◯ No	If yes
Do you, or have you had any type of Cancer? Please explain:	◯ Yes ◯ No	If yes
Do you, or have you had Diabetes? Please explain:	◯ Yes ◯ No	If yes
Do you, or have you had Hepatitis? Type A Type B Type C (circle one): Please explain:	◯ Yes ◯ No	If yes
Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

Comments:

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:

X Date:____________