Totem Lake Smiles Medical History

Patient Name:____Birth Date:_______________________Date Completed:___________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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:____
Have you ever been hospitalized or had a major operation? ___Yes ___No If yes:____
Have you had a serious head or neck injury? ___Yes ___No If yes:____
Are you taking any medications, pills, or drugs? ___Yes ___No If yes:____
Do you take, or have you taken, Phen-Fen or Redux? ___Yes ___No If yes:____
Have you ever taken Fosaman, Boniva, Actonel or any other medications containing bisphosphonates? ___Yes ___No If yes:____
Are you on a special diet? ___Yes ___No If yes:____
Do you use tobacco? ___Yes ___No If yes:____

Women only: Are you… ___Pregnant/Trying to get pregnant? ___Nursing? ___Taking oral contraceptives?

Are you allergic to any of the following?

___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal

___Sulfa Drugs ___Local Anesthetics ___Latex ___Other:_________________________

Do you use controlled substances? ___Yes ___No If yes:____

Please mark if you have, or have had, any of the following:

AIDS/HIV positive	___	Cortisone Medicine	___	Hemophilia	___	Radiation Treatments	___
Alzheimers Disease	___	Diabetes	___	Hepatitis A	___	Recent weight loss	___
Anaphylaxis	___	Drug Addiction	___	Hepatitis B or C	___	Renal Dialysis	___
Anemia	___	Easily winded	___	Herpes	___	Rheumatic Fever	___
Angina	___	Emphysema	___	High Blood Press	___	Rheumatism	___
Arthritis/Gout	___	Epilepsy/Seizures	___	High Cholesterol	___	Scarlet Fever	___
Artificial Hrt Valve	___	Excessive bleeding	___	Hives or rash	___	Shingles	___
Artificial joint	___	Excessive thirst	___	Hypoglycemia	___	Sickle Cell disease	___
Asthma	___	Fainting/dizziness	___	Irregular heartbeat	___	Sinus trouble	___
Blood disease	___	Frequent cough	___	Kidney problems	___	Spina Bifida	___
Blood transfusion	___	Frequent diarrhea	___	Leukemia	___	Stomach/intestinal disease	___
Breathing issues	___	Frequent headache	___	Liver disease	___	Stroke	___
Bruise easily	___	Genital herpes	___	Low blood pressure	___	Swelling of limbs	___
Cancer	___	Glaucoma	___	Lung disease	___	Thyroid disease	___
Chemotherapy	___	Hay fever	___	Mitral Valve Prolapse	___	Tonsillitis	___
Chest pains	___	Heart attack/failure	___	Osteoporosis	___	Tuberculosis	___
Cold sores	___	Heart Murmur	___	Pain in jaw joints	___	Tumors/Growths	___
Convulsions	___	Heart Pacemaker	___	Parathyroid Disease	___	Ulcers	___
		Heart disease/trouble	___	Psychiatric care	___	Venereal disease	___
		Heart disease-congenital	___			Yellow Jaundice	___

Have you ever had any serious illness not listed above? _____ If yes, please explain____
____

Is there anything else you feel the doctor should know?____
____

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 the patient's) health. It is my responsibility to inform this dental office of any changes in medical status

Signature of Patient, Parent, or Guardian____Date:_____________________________________