IMPERIAL FAMILY DENTAL CENTER

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 take could affect your treatment outcomes.

Do you have a primary care physician? If yes, name and location. Yes No If yes_____

Are you currently taking any medications? If yes, Please list. Yes No If yes_____

Have you been hospitalized or had a major operation in the past

10 years? Yes No If yes_____

Have you ever had a serious head or neck injury? Yes No If yes_____

Have you ever taken medications containing biphosphates?

Ex: Fosamax, Boniva, or Actonel Yes No If yes_____

Do you use tobacco products? 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

Any other allergies_____

What is your preferred Pharmacy_____

Do you use recreational drugs?_____

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

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments	Alzheimer's 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 Pressure	Rheumatism
Arthritis/Gout	Epilepsy/Seizures	High Cholesterol	Scarlet Fever	Artificial Heart Valve
Excessive Bleeding	Hives or Rash	Shingles	Sickle Cell Disease	Sinus Trouble
Spina Bifida	Stomach/Intes Disease	Stroke	Swelling of Limbs	Ulcers
Thyroid Disease	Tonsillitis	Tuberculosis	Tumors/Growths	Venereal Disease
Hypoglycemia	Irregular Heartbeat	Kidney Problems	Leukemia	Liver Disease
Low Blood Pressure	Lung Disease	Mitral Valve Prolapse	Osteoporosis	Pain in Jaw Joints

Excessive Thirst	Fainting Spells/Dizziness	Frequent Cough	Frequent Diarrhea	Frequent Headaches
Genital Herpes	Glaucoma	Hay Fever	Heart Attack/Failure	Heart Murmur
Heart Pacemaker	Heart Trouble/Disease	ADHD/Autism/ODD	Asthma	Blood Disease
Blood Transfusion	Breathing Problems	Bruise Easily	Cancer	Chemotherapy
Chest Pains	Cold Sores/Fever Blist	Congenital Hrt Disorder	Convulsions	Yellow Jaundice
Parathyroid Disease	Psychiatric Care	Other_____		

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/Guardian:_____Date: _____