In-House Dental Care 9506 Hamilton Ave. Huntington Beach, CA 92646 O. (949) 339-5373 F. (949) 339-5383

Today's Date: _____

MEDICAL HISTORY

Patient's First Name: _____ Patient's Last Name: _____ DOB: _____Age _____

Name of Responsible Party (or Power of Attorney/POA): _____.

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 Name / Phone of Physician: _____

Have you had an artificial joint replacement? ☐ Yes ☐ No Please specify year: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No Please provide list of Medications: _____

_____

Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia, or Skelide)? ☐ Yes ☐ No

Do you have depressed immune system? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic

☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics

Other: ☐ _____

Do you use controlled substances? ☐Yes ☐No

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

AIDS/ HIV Positive ☐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 or 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 ☐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/Intestinal Disease ☐Yes ☐No
Breathing Problems ☐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
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	Tuberculoses ☐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

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.

X_____ _____ / _____/ _____

Patient/ Responsible Party/ Power of Attorney Date