## Briggs Family And Cosmetic Dentistry MEDICAL HISTORY Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body.

Patient Name:

Health problems that you may have, or medication(s) that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever taken Fosamax, Boniva, Actonel, or any other medications, pills, and/or supplements? If so, please list:    Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?   Yes No If yes   Yes No O you take, or have you taken, Phen-Fen or Redux?   Yes No O you take, or have you taken, Phen-Fen or Redux?   Yes No O you take, or have you taken, Phen-Fen or Redux?   Yes No O you take, or have you taken grid to the your taken grid t	urgent care?  Have you ever had a serious head or neck injury?  Are you taking any medications, pills, and/or			<ul><li>○ Yes ○ No</li><li>○ Yes ○ No</li></ul>						
Are you laking any medications, pills, and/or Yes No If yes supplements? If so, please list:    Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?   Yes No If yes			seen at 🦿							
Are you teking any medications, pills, and/or Yes No If yes supplements? If so, please list:    Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?			eck injury?	Yes No	If vac					
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?  Do you take, or have you taken, Phen-Fen or Redux?  Do you used you have you taken, Phen-Fen or Redux?  Do you use or have you taken, Phen-Fen or Redux?  Do you use or have you taken, Phen-Fen or Redux?  Do you use or have you taken, Phen-Fen or Redux?  Do you use or have you used controlled substances?  Yes No  If yes  Do you use or have you used controlled substances?  Was No  If yes  Do you use or have you used controlled substances?  Was No  If yes  Codeline  Sulfa Drugs  Actylic  Local Anesthetics  Codeline  Sulfa Drugs  Actylic  Actylic  Actylic  Actylic  Actylic  Local Anesthetics  Codeline  Sulfa Drugs  Actylic  Actylic								*, **	Carl a min	
any other medications containing bisphosphonates?  Do you take, or have you been told to premedicate prior to dental treatment? If so, list the physician and why re you alergic to any of the following?  Aspirin  Metal  O you see or have you seed controlled substances? Yes Itio  Howe you been told to premedicate prior to dental treatment? If so, list the physician and why re you alergic to any of the following?  Aspirin  Metal  O you see or have you been told to premedicate prior to dental treatment? If so, list the physician and why re you alergic to any of the following?  Aspirin  Metal  O you have, or have you had, any of the following?  Hormone Replacement Therapy?  O you have, or have you had, any of the following?  Allos/Int Positive  Yes Itio  Allergies  Allorgies  Yes Itio  Artificial Positive  Yes Itio  Artificial Joint  Yes Itio  Conquals Heart Disorder  Yes Itio  Computal Heart Disorder  Yes Itio  Computal Heart Disorder  Yes Itio  Convulsions  Yes Itio  Convulsions  Yes Itio  Convulsions  Yes Itio  Easing Disorder  Yes Itio  Glaucoma  Yes Itio  Heart Murrur  Yes Itio  Heart Murrur  Yes Itio  Glaucoma  Yes Itio  Heart Murrur  Yes Itio  Heart Murrur  Yes Itio  Glaucoma  Yes Itio  Heart Murrur  Yes Itio  Heart Murrur  Yes Itio  Stroke  Yes Itio  Swelling Prowiting  Yes Itio  Swelling Prowiting  Yes Itio  Swelling Prowiting  Yes Itio  Heart Murrur  Yes Itio  Swelling Glaucoma  Y	Sopplements: If so, pie	rase risc:			- TT   T   T   T   T   T   T   T   T   T			The state of the s	= = = 1	
Do you take, or have you taken, Phen-Fen or Redux? Yes 110 If yes  Do you routinely drink soda, energy drinks, or yes 110 aronage juice?  Do you use or have you used controlled substances? Yes 110 Have you been told to premedicate prior to dental treatment? If so, list the physician and vrby yer you alergic to any of the following?  Aspirin Metal	Have you ever taken Fo	samax, Boniva,	Actonel, or	Yes 🗇 No	If yes		(846.3)			
Do you routinely drink soda, energy drinks, or orange juice? Do you use or have you ever used tobacco? Ves No Have you been told to premedicate prior to dental treatment? If so, list the physician and why re you alergic to any of the following?    Aspirin	Do you take, or have yo	u taken Phen-E	en or Pedus?		502					
Do you use or have you ever used tobacco?  Do you use or have you used controlled substances?  Way been told to premedicate prior to dental treatment? If so, list the physician and why re you alergic to any of the following?  Aspirin  Penicillin  Metal  Codeine  Sulfa Drugs  Codeine  Sulfa Drugs  Codeine  Sulfa Drugs  Codeine  Sulfa Drugs  Codeine  Codeine  Sulfa Drugs  Codeine  Sulfa Drugs  Taking oral contraceptives?  Taking oral contraceptives?  Taking oral contraceptives?  Anaphylaxis  Yes No  Anaphylaxis  Yes No  Angina  Yes No  Angina  Yes No  Angina  Yes No  Cancer  Yes No  Cancer  Yes No  Congental Heart Disorder  Yes No  Eating Disorder  Yes No  Glaucoma  Eating Disorder  Yes No  Glaucoma  Glaucoma  Heart Attack/Failure  Yes No  Glaucoma  Heart Murmur  Yes No  Glaucoma  Heart Murmur  Yes No  Glaucoma  Yes No  Heart Murmur  Yes No  Heart Murmur  Yes No  Glaucoma  Yes No  Heart Murmur  Yes No  Heart Hosoere  Yes No  Heart Proble/Disease  Yes No  Nitrial Valve Prolopse  Nitrial Valve Prolopse  Nitrial Valve Prolopse  Nitrial Valve Prolopse  Yes No  Nitrial Valve Prolopse  Nitrial Valve Prolopse  Yes No  Skeldation Treatment  Yes No  Skelmadition Treatment  Yes No  Nursing?  Taking oral contraceptives?  Itaking Docal Acrylic  Acryli	Do you routinely drink s				If yes		7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	And a surger		
Do you use or have you used controlled substances? Yes No If yes   Have you been told to premedicate prior to dental treatment? If so, list the physician and why re you allergic to any of the following?     Aspirin		ever used tobac	co2	Vac						
Have you been told to premedicate prior to dental treatment? If so, list the physician and why re you allergic to any of the following?    Aspirin										
Asprirn	Have you been told to p treatment? If so, list the	remedicate prior	r to dental		If ves		The second se	en de la companya de		
Metal		the following?	F-3							
O you have, or have you had, any of the following?  AIDS/HIV Positive			The Paris of the same of the s					Acrylic		
WOMEN Office of the following?  AIDS/HIV Positive Yes No Angina Yes No Angina Yes No Concert Yes	L. Metal		Latex			Sulfa Drugs		Local Anesthetics		
Pregnant/ Trying to get pregnant?	other?			Yes No	If ves					
O you have, or have you had, any of the following?  AIDS/HTV Positive Yes No Angina Yes No Arthritis Yes No Arthritis Yes No Arthritis Yes No Concertal Heart Disorder Yes No Communication Yes No Congenital Heart Disorder Yes No Convulsions Yes No Easily Winded Yes No Excessive Bleeding Yes No Glaucoma Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Pacemaker Yes No Heart Pacemaker Yes No Disopona/Osteoporosis Yes No Stoomach/Intestnal Disease Yes No Stoomach/Intestnal Disease Yes No Thypoid Disease Yes No Stoomach/Intestnal Disease Yes No Thypoid Disease Yes No Thypoid Disease Yes No Stoomach/Intestnal Disease Yes No Thypoid Disease Yes No Thypoid Disease Yes No Thypoid Disease Yes No Stoomach/Intestnal Disease Yes No Thypoid Disease Yes No Thypoid Disease Yes No Thypoid Disease Yes No Thypoid Disease Yes No Stoomach/Intestnal Disease Yes No Thypoid Disease Yes No Stoomach/Intestnal Disease Yes No Thypoid Disease Ye	WOMEN ONLY				,			****		
Anemia Yes No Arthritis Yes No Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Chest Pain Yes No Chest Pain Yes No Diabetes Yes No D	Hormone Replaceme	nt Therapy?			I/ Menop	ausal?	□   Taking ora	al contraceptives?		
AIDS/HIV Positive Yes No Anemia Yes No Anemia Yes No Angina Yes No Ashma Yes No Concer Yes No Chemotherapy Yes No Chemotherapy Yes No Congenial Heart Disorder Yes No Convulsions Yes No Easily Winded Yes No Easily Winded Yes No Excessive Bleeding Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Osteopenia/Osteoporosis Yes No Osteopenia/Osteoporosis Yes No Shingles/ Chicken Pox Stomach/Intestinal Disease Yes No Venereal Di	o you have, or have you	had, any of the	following?							
Anemia Yes No Artificial Joint Yes No Blood Disease Yes No Blood Disease Yes No Cold Sores Yes No Congenital Heart Disorder Yes No Eating Disorder Yes No Eating Disorder Yes No Easily Winded Yes No Excessive Bleeding Yes No Excessive Bleeding Yes No Heart Attack/Failure Yes No Glaucoma Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Attack/Failure Yes No High Blood Pressure Yes No Osteopenia/Osteoporosis Yes No Shingles/ Chicken Pox Yes No Shingles/ Chicken Pox Yes No Stomach/Intestnal Disease Yes No Stomach/Intestnal Disease Yes No Stomach/Intestnal Disease Yes No Ye				○ Yes	O No	Alzheimer's Disease	C Yes No	Ananhylavie	Var	i i
Artificial Joint Yes No Cancer Yes No Chemotherapy Yes No Chemothe	Anemia	○ Yes ○ No	Angina	O Yes	⊙ No			[1]		110
Cancer Yes No Chemotherapy Yes No Chest Pain Yes No Cold Sores Yes Congenital Heart Disorder Yes No Eating Disorder Yes No Heart Attack Failure Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Pacemaker Yes No Unit Disorder Yes No Osteopenia/Osteoporosis Yes No Osteopenia/Osteoporosis Yes No Stomach/Intestinal Disorder Yes No Y	Artificial Joint	O Yes O No	Asthma	○ Yes	○ No					110
Conquental Heart Disorder Eating Disorder Eating Disorder Excessive Bleeding Frequent Headaches Frequent Headaches Frequent Headaches Frequent Headaches Frequent Heart Murmur Heart Attack/Failure Heart Attack/Failure Heart Murmur High Blood Pressure Low Blood Pressure Ves No Osteopenia/Osteoporosis Radiation Treatment Shingles/ Chicken Pox Stomach/Intesthal Disease Ves No Venereal Disease Ves No Ves No Sainus Trouble Sconvulsions Yes No Easily Winded Yes No Emphysema Yes No Fainting/ Dizziness Yes No Heard of Hearing/Hearing Yes No Heard Pacemaker Yes No Heart Pacemak		O Yes No	Chemotherapy	Yes	ONO 🕒	Chest Pain			Yes	-110
Easily Winded Yes No Excessive Bleeding Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Murmur Yes No High Blood Pressure Yes No Osteopenia/Osteoporosis Yes No Osteopenia/Osteoporosis Yes No Shingles/ Chicken Pox Stomach/Intestinal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Winter Interval Disease Yes No Venereal Disease Yes No Ven			Convulsions	Yes	. No	Diabetes	Yes No		Yes	110
Excessive Bleeding Yes No Frequent Headaches Yes No Glaucoma Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Hemophilia Yes No Hepatitis A Yes No High Blood Pressure Yes No Osteopenia/Osteoporosis Yes No Osteopenia/Osteoporosis Yes No Shingles/ Chicken Pox Stomach/Intestinal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Glaucoma Yes No Heart Attack/Failure Yes No Glaucoma Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Pacemaker Y	(5) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1		Easily Winded	○ Yes	; ⊖ No	Emphysema	Yes No		Yes	No
Frequent Headaches Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Hemophilia Yes No Hemophilia Yes No High Blood Pressure Yes No Usual Disease Yes No Osteopenia/Osteoporosis Yes No Stomach/Intestinal Disease Yes No Yes No Yes No Yes No Yes No Yes No Stomach/Intestinal Disease Yes No Yes			Excessive Thirs	∵ Yes	⊙ No		Yes No	] [[15] [[17	Yes	110
Heart Attack/Failure  Yes No Hemophilia  Yes No Hepatitis A  Yes No High Blood Pressure Low Blood Pressure Osteopenia/Osteoporosis  Yes No Shingles/ Chicken Pox Stomach/Intestinal Disease Yes No Venereal Disease Yes No  Heart Murmur  Yes No Hepatitis A  Yes No Hepatitis A  Yes No Hepatitis B or C Hepatitis B or	[H. P. B. M.		Glaucoma	Yes	ON 🕒		🔾 Yes 💆 No	1 (3)	Yes	- 140
High Blood Pressure Yes No Low Blood Pressure Yes No Osteopenia/Osteoporosis Yes No Radiation Treatment Yes No Shingles/ Chicken Pox Stomach/Intestinal Disease Yes No Tonsilitis Yes No Venereal Disease Yes No  High Cholesterol Yes No Lung Disease Yes No Lung Disease Yes No Hives or Rash Yes No Mitral Valve Prolapse Yes No Recent Weight Loss Yes No Recent Weight Loss Yes No Sinus Trouble Yes No Stroke Yes No Venereal Disease Yes No Venereal Disease Yes No  Hepatitis B or C Yes No Mitral Valve Prolapse Yes No Rheumatic Fever Yes No Sjogren's Syndrome Yes No Swelling of Limbs Yes No Tumors or Growths Yes No Tumors or Growths Yes No			Heart Murmur	() Yes	ON O	The state of the s		Heart Trouble/Disease	Yes	110
Low Blood Pressure Yes No Osteopenia/Osteoporosis Yes No Osteopenia/Osteoporosis Yes No Radiation Treatment Yes No Shingles/ Chicken Pox Yes No Stomach/Intestinal Disease Yes No Stomach/Intestinal Disease Yes No			Hepatitis A					Herpes (cold sores)	Yes	110
Osteopenia/Osteoporosis				I Yes	○ No			Hypoglycemia	Yes	110
Radiation Treatment Yes No Shingles/ Chicken Pox Yes No Stomach/Intestinal Disease Yes No Venereal Disease Yes No Ves No			DESCRIPTION OF THE PROPERTY OF		ONO.			Multiple Sclerosis	Yes	No
Shingles/ Chicken Pox Yes No Stomach/Intestinal Disease Yes No Venereal Diseas			Pain in Jaw Join	ts 🖰 Yes	O No	The state of the s		Psychiatric Care	Yes	-110
Stomach/Intestinal Disease Yes No Tonsilitis Yes No Venereal Disease Yes No Venereal Disease Yes No  Tonsolitis Yes No Venereal Disease Yes No Venereal Disease Yes No			010	Loss 🔘 Yes	○ No			Scarlett Fever	Yes	110
Tonsilitis Yes No Tuberculosis Yes No Tumors or Growths Yes No Ulcers Yes	#550 - 8-300 Paring Paring (PROSE (1997) (19		The state of the s	○ Yes	. ○ No	i .		Sleep Apnea	Yes	110
Venereal Disease Yes No Tumors or Growths Yes No				Yes	○ No			Thyroid Disease	Yes	110
Have you had any angles at the same of the			Tuberculosis	· Yes	○ No			Ulcers	Yes	110
Have you had any serious illness not listed? Yes No If yes	venereal Disease		L			Tumors or Growins	165 _ 110			
			ed?	Yes No	If yes					
	Have you had any seriou	is liness not list								
	Have you had any seriou	is liness not list	**			* * · · · · · · · · · · · · · · · · · ·				
	Have you had any seriou	is liness not list		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		* * * ********************************				

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may 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: