Time 10:44 AM

Briggs Family And Cosmetic Dentistry

MEDICAL HISTORY

Date 2/9/2017

Patient Name: 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.

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.

Are you under a physician's care now? Yes No If yes

Have you recently been hospitalized or seen at urgent care? Yes No If yes

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

Are you taking any medications, pills, and/or supplements? If so, please list: Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Do you routinely drink soda, energy drinks, or orange juice? Yes No

Do you use or have you ever used tobacco? Yes No

Do you use or have you used controlled substances? Yes No

Have you been told to premedicate prior to dental treatment? If so, list the physician and why Yes No If yes

Are you allergic to any of the following?

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

other? Yes No If yes

* WOMEN ONLY

- Pregnant/ Trying to get pregnant?
- Hormone Replacement Therapy?
- Nursing?
- Perimenopausal/ Menopausal?
- Taking oral contraceptives?

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	Yes	No	Allergies	Yes	No	Alzheimer's Disease	Yes	No	Anaphylaxis	Yes	No
Anemia	Yes	No	Angina	Yes	No	Arthritis	Yes	No	Artificial Heart Valve	Yes	No
Artificial Joint	Yes	No	Asthma	Yes	No	Blood Disease	Yes	No	Breathing Problems	Yes	No
Cancer	Yes	No	Chemotherapy	Yes	No	Chest Pain	Yes	No	Cold Sores	Yes	No
Congenital Heart Disorder	Yes	No	Convulsions	Yes	No	Diabetes	Yes	No	Drug Addiction	Yes	No
Eating Disorder	Yes	No	Easily Winded	Yes	No	Emphysema	Yes	No	Epilepsy or Seizures	Yes	No
Excessive Bleeding	Yes	No	Excessive Thirst	Yes	No	Fainting/ Dizziness	Yes	No	Frequent Cough	Yes	No
Frequent Headaches	Yes	No	Glaucoma	Yes	No	Hard of Hearing/Hearing Aids	Yes	No	Hay Fever	Yes	No
Heart Attack/Failure	Yes	No	Heart Murmur	Yes	No	Heart Pacemaker	Yes	No	Heart Trouble/Disease	Yes	No
Hemophilia	Yes	No	Hepatitis A	Yes	No	Hepatitis B or C	Yes	No	Herpes (cold sores)	Yes	No
High Blood Pressure	Yes	No	High Cholesterol	Yes	No	Hives or Rash	Yes	No	Hypoglycemia	Yes	No
Low Blood Pressure	Yes	No	Lung Disease	Yes	No	Mitral Valve Prolapse	Yes	No	Multiple Sclerosis	Yes	No
Osteopenia/Osteoporosis	Yes	No	Pain in Jaw Joints	Yes	No	Parathyroid Disease	Yes	No	Psychiatric Care	Yes	No
Radiation Treatment	Yes	No	Recent Weight Loss	Yes	No	Rheumatic Fever	Yes	No	Scarlett Fever	Yes	No
Shingles/ Chicken Pox	Yes	No	Sinus Trouble	Yes	No	Sjogren's Syndrome	Yes	No	Sleep Apnea	Yes	No
Stomach/Intestinal Disease	Yes	No	Stroke	Yes	No	Swelling of Limbs	Yes	No	Thyroid Disease	Yes	No
Tonsilitis	Yes	No	Tuberculosis	Yes	No	Tumors or Growths	Yes	No	Ulcers	Yes	No
Venereal Disease	Yes	No									

Have you had any serious illness not listed? Yes No If yes

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:

X

Date:__________