Minster Dental Care Health 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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank for answering the following.

Are you under a physician's care now?	☐ YES ☐ NO	If yes, why:
Have you ever been hospitalized or had a major operation?	☐ YES ☐ NO	If yes, why:
Have you ever had a serious neck injury?	☐ YES ☐ NO	If yes, why:
Are you taking any medications, pills, or drugs?	☐ YES ☐ NO	If yes, why:
Do you require pre-medication or an antibiotic prior to dental procedures?	☐ YES ☐ NO	If yes, why:
Do you take, or have you taken, Phen-Fen or Redux?	☐ YES ☐ NO	If yes, why:
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐ YES ☐ NO	If yes, why:
Are you on a special diet?	☐ YES ☐ NO	If yes, what:
Do you use tobacco?	☐ YES ☐ NO	If yes, what:
Do you use controlled substances?	☐ YES ☐ NO	If yes, why:

Women: Are you...

☐ Pregnant or trying to get pregnant? ☐ Nursing? ☐ Taking oral contraception?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthesia

Other:

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

AIDS/HIV	Y / N	Cortisone Medicine	Y / N	Hemophilia	Y / N	Radiation Treatment	Y / N
Alzheimer's Disease	Y / N	Diabetes	Y / N	Hepatitis A	Y / N	Recent Weight Loss	Y / N
Anaphylaxis	Y / N	Drug Addiction	Y / N	Hepatitis B or C	Y / N	Renal Dialysis	Y / N
Anemia	Y / N	Easily Winded	Y / N	Herpes	Y / N	Rheumatic Fever	Y / N
Angina	Y / N	Emphysema	Y / N	High Blood Pressure	Y / N	Rheumatism	Y / N
Arthritis / Gout	Y / N	Epilepsy or Seizures	Y / N	High Cholesterol	Y / N	Scarlet Fever	Y / N
Artificial Heart Valve	Y / N	Excessive Bleeding	Y / N	Hives or Rash	Y / N	Shingles	Y / N
Artificial Joint	Y / N	Excessive Thirst	Y / N	Hypoglycemia	Y / N	Sickle Cell Disease	Y / N
Asthma	Y / N	Fainting / Dizziness	Y / N	Irregular Heartbeat	Y / N	Sinus Trouble	Y / N
Blood Disease	Y / N	Frequent Cough	Y / N	Kidney Problems	Y / N	Spina Bifida	Y / N
Blood Transfusions	Y / N	Frequent Diarrhea	Y / N	Leukemia	Y / N	Stomach/Intestinal Issues	Y / N
Breathing Problems	Y / N	Frequent Headaches	Y / N	Liver Disease	Y / N	Stroke	Y / N
Bruise Easily	Y / N	Genital Herpes	Y / N	Low Blood Pressure	Y / N	Swelling of Limbs	Y / N
Cancer	Y / N	Glaucoma	Y / N	Lung Disease	Y / N	Thyroid Disease	Y / N
Chemotherapy	Y / N	Hay Fever	Y / N	Mitral Valve Prolapse	Y / N	Tonsillitis	Y / N
Chest Pains	Y / N	Heart Attack/Failure	Y / N	Osteoporosis	Y / N	Tuberculosis	Y / N
Cold Sores/Fever Blisters	Y / N	Heart Murmur	Y / N	Pain in Jaw Joints	Y / N	Tumors or Growths	Y / N
Congenital Heart Disorder	Y / N	Heart Pacemaker	Y / N	Parathyroid Disease	Y / N	Ulcers	Y / N
Convulsions	Y / N	Heart Trouble/Disease	Y / N	Psychiatric Care	Y / N	Venereal Disease	Y / N
Yellow/Jaundice	Y / N	Brain Damage	Y / N	Circulatory Problems	Y / N	Parkinson's Disease	Y / N

Have you ever had any serious illness not listed above? If yes, what:

Comments:

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 Minster Dental Care of any changes in medical status.

SIGNATURE OF PATIENT / PARENT / GUARDIAN: DATE: