CONFIDENTIAL MEDICAL HISTORY

Uxbridge Dental

First Name:_____

Have you recently been hospitalized or had a major operation? ◯ Yes ◯ No

Reason _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No

List all **medications**, pills, vitamins, or herbs you are presently taking:

_____

_____

Have you ever taken Fosamax, Risedronate, Boniva, Actonel or any other medications containing bisphosphonates (Medication used to treat osteoporosis and bone conditions)? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Yes Do you have ALLERGIES to?

- ☐ ASPIRIN
- ☐ CODEINE
- ☐ ERYTHROMYCIN
- ☐ LATEX
- ☐ LOCAL ANESTHETIC FREEZING
- ☐ PENICILLIN
- ☐ SULPHA
- ☐ OTHER: PLEASE LIST

Women only:

Are you pregnant? ◯ Yes ◯ No Due Date: _____

Are you Breastfeeding? ◯ Yes ◯ No

Health Information *(Please check all that apply to you)*

- ☐ HIV OR AIDS
- ☐ ALCOHOL OR DRUG ABUSE
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL VALVES/JOINTS/PINS
- ☐ ASTHMA (INHALER: Y◯ N◯)
- ☐ BLOOD DISORDER TRANSFUSION
- ☐ HIGH BLOOD PRESSURE
- ☐ CANCER/CHEMO
- ☐ CONGESTIVE HEART FAILURE
- ☐ DIABETES (INSULIN: Y◯ N◯)
- ☐ DIZZINESS/FAINTING
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ GLAUCOMA
- ☐ GROWTHS OR TUMORS
- ☐ HAY FEVER
- ☐ HEAD INJURIES
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS/ TYPE: ____
- ☐ STD/VENEREAL DISEASE
- ☐ JAUNDICE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MENTAL OR NERVOUS
- ☐ DISORDERS PACEMAKER
- ☐ TUBERCULOSIS
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY PROBLEMS (sleep apnea COPD)
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE (WHEN _____)
- ☐ TMJ PROBLEMS
- ☐ OTHER _____

IMPORTANT: Do you require PREMEDICATION (ANTIBIOTIC COVERAGE) for your dental treatment? ◯ Yes ◯ No

(i.e.: Heart valve problems, heart disorders, artificial hip, ect)

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, or GUARDIAN _____

DATE _____