Indian Creek Dental Patient Medical History

Patient Name: _____ Date of Birth: _____ Medical Physician's Name_____

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 are taking, could have an important correlation with the dentistry you will receive. Thank you for answering the following questions.

Have you been a patient in a hospital in the past 2 years? O Yes O No If yes, please explain: _____

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____

Have you ever been told to take antibiotic pre-medication before dental treatment? O Yes O No If yes, for what: _____

Have you had excessive bleeding requiring special treatment? O Yes O No If yes, please explain: _____

Do you currently or have you previously used tobacco in any form? O Yes O No If yes, which type, amount, and years of use: _____

Do you or have you taken medications for osteoporosis or bone disease? O Yes O No If yes, which medication (oral or IV): _____

Have you undergone or are you currently undergoing cancer treatment? O Yes O No If yes: Chemotherapy or Radiation. Area of Body: _____ Year : _____

Have you had a joint replacement? O Yes O No If yes, Which joint: _____ Date of Placement: _____
Orthopedic Surgeons/s Name: _____

Please list all of your medications and reason for use below (attach medication list if necessary):

Medication	Use	Medication	Use	Medication	Use

Women: Are you: Pregnant? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following (rash, hives, anaphylaxis)? O No Known Allergies
O Aspirin O Penicillin/Amoxicillin O Codeine O Latex O Sulfa O Other Medication_____

If yes, please describe reaction: _____

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

Anemia	O Yes O No	Fainting	O Yes O No	HIV Positive/AIDS	O Yes O No
Arthritis	O Yes O No	GERD/Acid Reflux	O Yes O No	Kidney Disease/Dialysis	O Yes O No
Asthma	O Yes O No	Hepatitis A, B, or C	O Yes O No	Liver Disease/Jaundice	O Yes O No
Blood/Bleeding Disorder	O Yes O No	Heart Trouble/Disease	O Yes O No	Neurological Disorders	O Yes O No
Cancer	O Yes O No	Artificial Heart Valve	O Yes O No	Sinus Issues – Chronic	O Yes O No
COPD/Emphysema	O Yes O No	Heart Murmur	O Yes O No	Sleep Apnea/Snoring	O Yes O No
Diabetes	O Yes O No	High Blood Pressure	O Yes O No	Special Needs (Not Specified)	O Yes O No
Drug/Alcohol Dependency	O Yes O No	Irregular Heart Beat	O Yes O No	Steroid Therapy (Long Term)	O Yes O No
Eating Disorder	O Yes O No	Pacemaker	O Yes O No	Thyroid Disease	O Yes O No
Epilepsy	O Yes O No	Stroke	O Yes O No	Tuberculosis	O Yes O No

Comments: _____

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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 the 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: _____