Burns Dental Care - Medical History

Patient Name:_____ Birth Date:_____ Date Created:_____

Are you under a physician's care now?	☐Yes	☐No	If yes_____
Have you ever been hospitalized or had a major operation in the last 5 years?	☐Yes	☐No	If yes_____
Have you ever had a serious head or neck injury?	☐Yes	☐No	If yes_____
Are you taking any medications, pills, or drugs?	☐Yes	☐No	If yes_____
Do you take a blood thinner? Medication:	☐Yes	☐No	If yes_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐Yes	☐No	If yes_____
Are you on a special diet?	☐Yes	☐No	
Do you use tobacco?	☐Yes	☐No	If yes how often?_____
Do you use controlled substances?	☐Yes	☐No	If yes_____

Joint Replacement:

Have you ever had a joint replacement or artificial heart valve? ☐Yes ☐No ☐DK

If yes, what was the surgery date? _____

Does your surgeon require you to pre-med? ☐Yes ☐No Name of Medication? _____ How long are you required to pre-med? _____

Name & Phone number of Surgeon or Surgeon's Office: _____

Do you premedicate? ☐Yes ☐No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐Other _____

Women: Are you...
☐Pregnant/Trying to get pregnant? ☐Nursing? ☐Taking oral contraception?

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

AIDS/HIV Positive	☐Yes	☐No	Excessive Bleeding	☐Yes	☐No	Lung Disease	☐Yes	☐No
Alzheimer's Disease	☐Yes	☐No	Excessive Thirst	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No
Anaphylaxis	☐Yes	☐No	Fainting Spells/Dizziness	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Anemia	☐Yes	☐No	Frequent Cough	☐Yes	☐No	Pain Jaw Joint	☐Yes	☐No
Angina	☐Yes	☐No	Frequent Diarrhea	☐Yes	☐No	Parathyroid Disease	☐Yes	☐No
Arthritis/Gout	☐Yes	☐No	Frequent Headaches	☐Yes	☐No	Psychiatric Care	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No	Genital Herpes	☐Yes	☐No	Radiation Treatment	☐Yes	☐No
Artificial Joint	☐Yes	☐No	Glaucoma	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No
Asthma	☐Yes	☐No	Hay Fever	☐Yes	☐No	Renal Dialysis	☐Yes	☐No
Anxiety/Depression	☐Yes	☐No	Heart Attack/Failure	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Blood Disease	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Rheumatism	☐Yes	☐No
Blood Transfusion	☐Yes	☐No	Heart Pacemaker	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Breathing Problems	☐Yes	☐No	Heart Trouble/Disease	☐Yes	☐No	Shingles	☐Yes	☐No
Bruise Easily	☐Yes	☐No	Hemophilia	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No
Cancer	☐Yes	☐No	Hepatitis A	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Hepatitis B or C	☐Yes	☐No	Spina Bifida	☐Yes	☐No
Chest Pains	☐Yes	☐No	Herpes	☐Yes	☐No	Stomach/Intestinal Disease	☐Yes	☐No
Cold Sores/Fever Blisters	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Stroke	☐Yes	☐No
Congenital Heart Disorder	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Swelling of Limbs	☐Yes	☐No
Convulsions	☐Yes	☐No	Hives or Rash	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Cortisone Medicine	☐Yes	☐No	Hypoglycemia	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Diabetes	☐Yes	☐No	Irregular Heartbeat	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Drug Addition	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Tumors or Growths	☐Yes	☐No
Easily Winded	☐Yes	☐No	Leukemia	☐Yes	☐No	Ulcers	☐Yes	☐No
Emphysema	☐Yes	☐No	Liver Disease	☐Yes	☐No	Yellow Jaundice	☐Yes	☐No
Epilepsy or Seizures	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No			

Have you ever had any serious illness not listed? ☐Yes ☐No If yes_____
Do you snore? Or have Sleep Apnea? ☐Yes ☐No

To the best of my knowledge, the questions on this form have been 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:

X_____ **Date**_____