Garden Gate
DENTAL

Medical History

Patient Name _____ Birth Date _____

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 you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes, please explain:	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes, please explain:	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes, please explain:	
Are you taking any medications, pills, or drugs	◯ Yes ◯ No	If yes, please explain:	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No		
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No		

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

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

Other ☐ If other, please explain: _____

Aids/HIV positive	◯ Yes	◯ No	Alzheimer's Disease	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Anemia	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Arthritis/Gout	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Artificial Joint	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Blood Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Breathing Problem	◯ Yes	◯ No

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Bruise Easily	◯ Yes	◯ No	Cancer	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Chest Pains	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Congenital Heart Disorder	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Cortisone Medication	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Drug Addiction	◯ Ye	◯ No
Easily Winded	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No
Epilepsy or Seizures	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No
Excessive Thirst	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No
Frequent Cough	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No
Frequent Headaches	◯ Yes	◯ No	Genital Herpes	◯ Yes	◯ No
Glaucoma	◯ 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	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No
Hives or Rash	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No
Irregular Heartbeat	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No
Leukemia	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No
Lung Disease	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No
Osteoporosis	◯ Yes	◯ No	Pain In Jaw Joints	◯ yes	◯ No
Parathyroid Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No
Radiation Treatments	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Renal Dialysis	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Rheumatism	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Shingles	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Sinus Trouble	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Stomach/Intestinal Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Swelling of Limbs	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Tumors or Growths	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Venereal Disease	◯ Yes	◯ No	Yellow Jaundice	◯ Yes	◯ No

Patient Name: _____

Have you ever had a serious illness not listed above? ◯ Yes ◯ No

What Illness? _____

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 the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date _____