EDGEVIEW DENTAL

Medical History

PATIENT NAME	DOB	DATE CREATED

Although dental personnel primarily treat the area in and around your month, your mouth is a part of your entire body.

Please list primary doctor's name and phone number.	☐ YES	☐ NO	IF YES
Are you taking any medications, pills, or drugs? If Yes, please list.	☐ YES	☐ NO	IF YES
Do you use controlled substances? If Yes, please list.	☐ YES	☐ NO	IF YES
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If Yes, for how long?	☐ YES	☐ NO	IF YES
Do you use tobacco (if yes, how much)?	☐ YES	☐ NO	IF YES
Do you have any anxiety, dental or otherwise? If Yes, please explain.	☐ YES	☐ NO	IF YES
What Pharmacy do you use? Name and location.	☐ YES	☐ NO	IF YES
Have you ever been diagnosed with Sleep Apnea? Have you had a sleep study done?	☐ YES	☐ NO	IF YES
Do you pre-medicate for dental appointments? If Yes, what for?	☐ YES	☐ NO	IF YES
Have you ever been hospitalized or had a major operation?	☐ YES	☐ NO	IF YES

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

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	Other Allergies? Please List ☐ YES ☐ NO
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	IF YES
☐ Gluten	☐ Ibuprofen			

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

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS or HIV positive	☐	☐	Circulatory Disorder	☐	☐	Fainting or Dizziness	☐	☐	Migraines	☐	☐
Alzhemiers or Dementia	☐	☐	COPD	☐	☐	Heart Attack or Failure	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Clench or Grind Teeth	☐	☐	Hypoglycemia	☐	☐	Osteoporosis	☐	☐
Angina or Chest Pains	☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐
Arthritis or Gout	☐	☐	Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Pacemaker	☐	☐
Artificial Heart Valve	☐	☐	Cortisone Medicine	☐	☐	Hepatitis A, B, or C	☐	☐	Radiation Treatment	☐	☐
Asthma	☐	☐	Dry Mouth	☐	☐	Heart Murmur	☐	☐	Swelling of Limbs	☐	☐
Artificial Joint	☐	☐	Diabetes	☐	☐	Herpes/cold sores/blisters	☐	☐	Stomach or Intestinal Disease	☐	☐
Acid Reflux	☐	☐	Drug Addiction	☐	☐	High Cholesterol	☐	☐	Stroke	☐	☐
Auto Immune Disorder	☐	☐	Epilepsy or Seizures	☐	☐	Kidney Disease	☐	☐	Sleep Apnea	☐	☐
Blood Disorder	☐	☐	Excessive bleeding	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Bruise Easily	☐	☐	Easily winded or Shortness of Breath	☐	☐	Leukemia	☐	☐	Thyroid Disease	☐	☐
Congenital Heart Disorder	☐	☐	Emphysema	☐	☐	Low Blood Pressure	☐	☐	Ulcers	☐	☐

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 _____