OJ Clinic 5 Burlington Family Dentistry

Medical History

Although the dental staff treats the area in and around your mouth, this is part of your body. The health problems you may have, or medication you are taking, may have an important interrelationship in the treatment you receive.

Are you under the care of your doctor? O Yes O No Explain_____

Have you ever been hospitalized or had a major operation? O Yes O No Explain _____

Have you had a serious head or neck injury? O Yes O No Explain_____

Are you taking any medications, pills or prescription drugs? O Yes O No Explain _____

Do you take or have you taken Phen-fen or Redux? O Yes O No Explain _____

Have you taken Fosamax, Boniva, Actonel or any other medicine containing bisphosphonates? O Yes O No Explain _____

Do you have any special diets? O Yes O No

Do you use tobacco? O Yes O No

Do you use controlled substances? O Yes O No

Preferred Pharmacy: _____City: _____

Women: Are You:

☐ **Pregnant/Trying to get pregnant?** ☐ **Breastfeeding?** ☐ **Taking oral contraceptives?**

Are you allergic to any of the following:

☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Acrylic** ☐ **Metal** ☐ **Latex** ☐ **Sulfa Drugs** ☐ **Local Anesthesia**

☐ **Other? Explain: _____**

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

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

Have you had any serious illnesses not listed? O Yes O No Explain _____

Comments:_____

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To the best of my knowledge, the questions in this questionnaire have been answered correctly. 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.

Patient Name: _____Signature:_____Date of Birth:_____Today's Date_____