Twin Cities Sedation Dental, PA

2015 Medical History

Patient Name: Birth Date:

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, supplements, or over-the-counters medications?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ 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	If yes
Do you use tobacco?	○ Yes ○ No	If yes
Do you use controlled substances?	○ 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 ☐ Amoxicillin ☐ Codeine
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other

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

AIDS/HIV Positive ○ Yes ○ No	Alzheimer's Disease ○ Yes ○ No	Anaphylaxsis ○ Yes ○ No	Anemia ○ Yes ○ No
Angina/Chest Pains ○ 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 Problems ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Cancer ○ Yes ○ No	Chemotherapy ○ Yes ○ No	Cold Sores/ Fever Blisters ○ Yes ○ No
Convulsions ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Diabetes ○ Yes ○ No	Drug Addiction ○ Yes ○ 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	Glaucoma ○ Yes ○ No	Hay Fever ○ Yes ○ No	Heart Attach/Failure ○ Yes ○ No
Heart Murmur ○ 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	Hypoglycemia ○ Yes ○ No
Irregular Heartbeat ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Leukemia ○ Yes ○ No	Liver Disease ○ Yes ○ No
Low Blood Pressure ○ Yes ○ No	Lung Disease ○ Yes ○ No	Mitral Value Prolapse ○ Yes ○ No	Osteoporosis ○ Yes ○ No
Pacemaker ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No
Radiation Treatments ○ 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	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	

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:

X Date:_____