Premier Dental Medical History

Patient Name: Birth Date: Date Created:

Question	Answer		
Are you under a Physician's care now? If yes, please give your Phyician's name and phone number.	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation? If yes, please explain.	◯ 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? If yes, please list.	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Do you use tobacco?	◯ Yes ◯ No		

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other Known Allergy? ☐ If yes

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

Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Artifical Heart Valve	◯ Yes ◯ No	Artifical Joint	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Cold Sores/FeverBlister	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Hemophilla	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Renal Dialysis	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Tonsillitis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:__________