MINIMALLY INVASIVE DENTAL AESTHETICS

Kevin M Brown

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 If yes, please explain: _____
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 ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Sulfa

Other If yes, please explain:_____

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

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments:_____
_____

Do we have your permission to use email to confirm your appointments? ☐Yes ☐ No
If yes, please provide:_____

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 _____