WESTHILL DENTAL EXCELLENCE

Medical History

www.westhilldentalappleton.com
Appleton: (920) 733-2445
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Although dental personnel primarily treat the are in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Patient's Name ______________________ Date of Birth __________ ☐ Male ☐ Female
Last First Initial

1. Are you under a physician's care now? **YES** **NO**
   If yes, who & why ______________________
2. Have you ever been hospitalized or had a major operation? **YES** **NO**
   If yes, explain ______________________
3. Have you ever had a serious head or neck injury? **YES** **NO**
   If yes, explain ______________________
4. Are you taking any medications, pills, or drugs? **YES** **NO**
   If yes, explain ______________________
5. Do you take, or have you taken, Phen-Fen or Redux? **YES** **NO**
   If yes, what and frequency? ______________________
6. Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? **YES** **NO**
   If yes, what and frequency? ______________________
7. Do you use tobacco? **YES** **NO**
   If yes, what type and how often? ______________________
8. Do you use controlled substances? **YES** **NO**
   If yes, what type and how often? ______________________
9. Are you on a special diet? **YES** **NO**

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking any oral contraceptives?

Are you allergic to any of the following?

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

Other? Please specify: ______________________

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

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores
☐ Congenital Hearth Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Hearth Pacemaker
☐ Hearth Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Yellow Jaundice
☐ Venereal Disease

Have you ever had any serious illness not listed above? **YES** **NO**
If yes, explain ______________________
Is there anything specific you'd like to change or address with your teeth? ______________________
On a scale of 1-10, how would you rate the health and look of your smile? (1=poor/10=excellent) ______________________
How did you hear about us? ______________________

To the best of my knowledge, all of the preceding answers are true and correct. I understand giving incorrect information can be dangerous to my (or patient's) health. If I ever have any changes in my medical/dental health, I will inform the dental office of any changes.

Patient's or Guardian's Signature ______________________ Date ______________________