LUMBERTON DENTAL CENTER, P.A.

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 will receive. Thank you for answering the following questions.

Patient Name:____**Birthday:**_____________________**Age:**_________

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 Please list all your medications:________________________________

Do you take, or have you taken Phen-Fen or Redux? ☐ YES ☐ NO

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Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES ☐ NO

Are you on a special diet? ☐ YES ☐ NO

Do you use controlled substances? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO

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

☐ Other If yes, please explain: ____

If you have, or have had any of the following please check.

☐ AIDS/HIV
☐ Alzheimer's
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/gout
☐ Artificial Heart Value
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart 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 Value Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Spinal Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers

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

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 my medical status.

Signature of patient, parent , guardian:____Date:__________________