Pace Dental

Medical History Information

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that may have , or medication that you may be taking, could h

Are you under a primary physician's care?	Yes No	If yes	
Have you ever been hopitalized or had major operation in the last 5 years?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, drugs, or herbal supplements?	Yes No	If yes	
Do you take or have you ever taken Fosamax, Boniva, Actonel, medications which contain 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	
Have you had complications or allergic reactions to dental treatment?	Yes No	If yes	

Women: Are you...

Pregnant/Trying to get pregnant?	Yes No	Nursing?	Yes No	Taking oral contraceptives?	Yes No

Are you allergic to any of the following?

Aspirin	Yes No	Metal	Yes No	Local Anesthetics	Yes No	Penicillin	Yes No
Latex	Yes No	Acrylic	Yes No	Codeine	Yes No	Sulfa Drugs	Yes No

Other? Yes No If yes

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

AIDS/HIV positive	Yes No	Dementia	Yes No	Anaphylaxis	Yes No	Anemia	Yes No
Angina	Yes No	Arthritis	Yes No	Artificial 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	Herpes/Cold sores/Fever Blisters	Yes No	Congenital Heart Disease	Yes No
Convulsions	Yes No	Steroids	Yes No	Diabetes	Yes No	Drug Addiction	Yes No
Emphysema	Yes No	COPD	Yes No	Epilepsy/Seizures	Yes No	Fainting Spells/Dizziness	Yes No
Frequent Headaches	Yes No	Glaucoma	Yes No	Hay Fever	Yes No	Heart Attack/Failure	Yes No
Heart Murmur	Yes No	Heart Pacemaker	Yes No	Hemophillia	Yes No	Hepatitis	Yes No
High Blood Pressure	Yes No	Low Blood Pressure	Yes No	High Cholesterol	Yes No	Hives/ Rash	Yes No
Irreugular Heartbeat	Yes No	Kidney Problems	Yes No	Leukemia	Yes No	Liver Disease	Yes No
Lung Disease	Yes No	Mitral Valve Prolapse	Yes No	Osteoporosis	Yes No	Pain in Jaw Joints	Yes No
Parathyroid Disease	Yes No	Psychiatric Care	Yes No	Radiation Treatment	Yes No	Renal Dialysis	Yes No
Rheumatic Fever	Yes No	Rheumatism	Yes No	Shingles	Yes No	Sickle Cell Disease	Yes No
Sinus Trouble	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 Growth	Yes No
Ulcers	Yes No	Venereal Disease	Yes No	Yellow Jaundice	Yes No	Depression	Yes No
Gout	Yes No						

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

Comments:

FOR OFFICE STAFF USE ONLY:

ASA Classification:

☐ ASA I II III IV V

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerours to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical history.

Signature of Patient, Parent or Guardian:

X Date:_____