Derry Dental Associates

Medical History

Patient Name: Birthdate: Social Security:

Address: Phone: Email:

Name and Phone Number of your primary care physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had a major operation? Y N If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a serious head or neck injury? Y N If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications, pills, or drugs you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you take, or have you taken, Phen-Fen or Redux? Y N If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel, Y N If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or any other medications containing bisphosphonates?

Are you on a special diet? Y N If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco? Y N If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use controlled substances? Y N If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been told you need to premedicate prior to dental treatment? Y N

Women: Are you:

Pregnant/Trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

AIDS/HIV Positive Yes No Cortisone Medicine Yes No

Alzheimer’s disease Yes No Diabetes Yes No

Anaphylaxis Yes No Drug Addiction Yes No

Anemia Yes No Easily Winded Yes No

Angina Yes No Emphysema Yes No

Arthritis/Gout Yes No Epilepsy Yes No

Artificial Heart Valve Yes No Excessive Bleeding Yes No

Artificial Joint Yes No Excessive Thirst Yes No

Asthma Yes No Fainting Spells/Dizziness Yes No

Blood Disease Yes No Frequent Cough Yes No

Blood Transfusion Yes No Frequent Diarrhea Yes No

Breathing Problems Yes No Frequent Headaches Yes No

Bruise Easily Yes No Genital Herpes Yes No

Cancer Yes No Glaucoma Yes No

Chemotherapy Yes No Hay Fever Yes No

Chest Pains Yes No Heart Attack/Failure Yes No

Cold Sores/Fever Blisters Yes No Heart Murmur Yes No

Congenital Heart Disorder Yes No Heart Pacemaker Yes No

Convulsions Yes No Heart Trouble/Disease Yes No

Yellow Jaundice Yes No Sleep Apnea Yes No

Hemophilia Yes No Radiation Treatments Yes No

Hepatitis A Yes No Recent Weight Loss Yes No

Hepatitis B or C Yes No Renal Dialysis Yes No

Herpes Yes No Rheumatic Fever Yes No

High Blood Pressure Yes No Rheumatism Yes No

High Cholesterol Yes No Scarlet Fever Yes No

Hives or Rash Yes No Shingles Yes No

Hypoglycemia Yes No Sickle Cell Disease Yes No

Irregular Heartbeat Yes No Sinus Trouble Yes No

Kidney Problems Yes No Spina Bifida Yes No

Leukemia Yes No Stomach/Intestinal Disease Yes No

Liver Disease Yes No Stroke Yes No

Low Blood Pressure Yes No Swelling of Limbs Yes No

Lung Disease Yes No Thyroid Disease Yes No

Mitral Valve Prolapse Yes No Tonsilitis Yes No

Osteoporosis Yes No Tuberculosis Yes No

Pain in Jaw Joints Yes No Tumors or Growths Yes No

Parathyroid Yes No Ulcers Yes No

Psychiatric Care Yes No Venereal Disease Yes No

Back Pain Yes No

Have you ever had any serious illness not listed above?

Additional Comments:

Signature of Patient, Parent, or Guardian:

X Date: