Bowers and Oki Family Dentistry

Patient Medical History

Patient Name_____ Date of Birth_____

Physicians Name_____

Address_____ Phone #_____

_____

Are you under a physicians care? If YES, please Explain_____

Have you ever been hospitalized or had a major operation? If YES, please Explain_____

Have you ever had a serious head or neck injury: If YES, please Explain_____

Have you ever taken any bisphosphonates such as Fosamax, Boniva, or Actonel?_____

Do you take, or have you taken, Phen-Fen, Redux or other weight loss products?_____

Are you on a special diet?_____

Do you smoke or use toboacco? If YES, how often/how much?_____

Do you drink alcohol? If YES, how often/how much?_____

Do you use controlled substances? Please list_____

Are you allergic to any of the following?

ASPIRIN CODEINE PENICILLIN ANESTHETICS ACRYLIC METAL LATEX SULFA DRUGS

Do you have any allergies not listed above?_____

WOMEN: Are you

Pregnant/Trying to get pregnant?	YES	NO
Nursing?	YES	NO
Taking oral contraceptives?	YES	NO

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

AIDS/HIV	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
Bacterial Endocarditis	YES NO	Frequent Cough	YES NO	Kidney Problems	YES NO	Spina Bifida	YES NO
Blood Disease	YES NO	Frequent Diarrhea	YES NO	Leukemia	YES NO	Stomach/Intestinal Disease	YES NO
Blood Transfusion	YES NO	Frequent Headaches	YES NO	Liver Disease	YES NO	Stroke	YES NO
Breathing Problem	YES NO	Genital Herpes	YES NO	Low Blood Pressure	YES NO	Swelling of Limbs	YES NO
Bruise Easily	YES NO	Glaucoma	YES NO	Lung Disease	YES NO	Thyroid Disease	YES NO
Cancer	YES NO	Hay Fever	YES NO	Mitral Valve Prolapse	YES NO	Tonsillitis	YES NO
Chemotherapy	YES NO	Heart Attack/Failure	YES NO	Osteoporosis	YES NO	Tuberculosis	YES NO
Chest Pains	YES NO	Heart Murmur	YES NO	Pain in Jaw Joints	YES NO	Tumors or Growths	YES NO
Cold Sores/Fever Blisters	YES NO	Heart Pacemaker	YES NO	Parathyroid Disease	YES NO	Ulcers	YES NO
Congenital Heart Disorder	YES NO	Heart Trouble/Disease	YES NO	Psychiatric Care	YES NO	Venereal Disease	YES NO
Convulsions	YES NO					Yellow Jaundice	YES NO

Have you ever had any serious illness not listed above? Yes NO If YES, please explain_____

Please list any medications, pills, drugs, substances that you are taking_____

_____

Comments: _____

_____

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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_____