Time 3:20 PM | Thomas J. Herrick, D.D.S. | Date 12/13/2017

Medical History

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 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.

Do you currently have a primary care physician?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes

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
☐ Tetracycline

Other? ☐ If yes

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

AIDS/HIV Positive ○ Yes ○ No	Diabetes ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's/Dementia ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema/Lung Disease ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Shingles ○ Yes ○ No
Arthritis ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Asthma ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Atrial Fibrillation ○ Yes ○ No	Glaucoma ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Blood Thinner ○ Yes ○ No	Gout ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tonsils Removed ○ Yes ○ No
Cancer ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Heart Disease ○ Yes ○ No	Parkinson's ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Ulcers ○ Yes ○ No

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

Comments:

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:

X Date:_____