Ireland Dental
Medical History

Patient Name: _____ Birth Date: _____ Today's Date: _____

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.

Are you under a physician's care now ?	○ 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:
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If Yes:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No	If Yes:
Are you on a special diet?	○ Yes	○ No	
Do you use tobacco?	○ Yes	○ No	

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? ○ Yes ○ No If Yes: _____

Do you use controlled substances ○ Yes ○ No If Yes: _____

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

AIDS/HIV Positive	● Yes ○ No	Excessive Thirst	○ Yes ○ No	Mitral Valve Problems	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No
Anemia	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Angina	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Glaucoma	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Hay Fever	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Asthma	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Blood Disease	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Rheumatism	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Shingles	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Hemophilia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Chest Pains	○ Yes ○ No	Herpes	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Stroke	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Convulsions	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Cortisone Medicine	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Diabetes	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Drug Addiction	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Easily Winded	○ Yes ○ No	Leukemia	○ Yes ○ No	Ulcers	○ Yes ○ No
Emphysema	○ Yes ○ No	Liver Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Lung Disease	○ 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 my 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: _____