Ireland Dental
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.

Are you under a physician's care now ?	☐ Yes	If Yes, Name
Have you ever been hospitalized or had a major operation?	☐ Yes	If Yes, Details
Have you ever had a serious head or neck injury?	☐ Yes	If Yes, Details
Are you taking any medications, pills, or drugs?	☐ Yes	If Yes, Details
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	If Yes, Details
Are you on a special diet?	☐ Yes	If Yes, Details
Do you use tobacco?	☐ Yes	If Yes, Details
Do you use controlled substances?	☐ Yes	If Yes, Details
Have you ever tested positive for COVID-19?	☐ Yes	If Yes, When

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	☐ Alzheimer's Disease	☐ Anaphylaxis	☐ Anemia
☐ Angina	☐ Arthritis/Gout	☐ Artificial Heart Valve	☐ Artificial Joint
☐ Asthma	☐ Attention Deficit Disorder	☐ Autism/Asperger's Syndrome	☐ Blood Disease
☐ Blood Transfusion	☐ Breathing Problems	☐ Bruise Easily	☐ Cancer
☐ Chemotherapy	☐ Chest Pains	☐ Cold Sores/Fever Blisters	☐ Congenital Heart Disorder
☐ Cortisone Medicine	☐ Diabetes	☐ Drug Addiction	☐ Easily Winded
☐ Emphysema	☐ Epilepsy or Seizures	☐ Excessive Bleeding	☐ Excessive Thirst
☐ Fainting Spells/Dizziness	☐ Frequent Cough	☐ Frequent Diarrhea	☐ Frequent Headaches
☐ Glaucoma	☐ Hay Fever	☐ Heart Attack/Failure	☐ Heart Murmur
☐ Heart Pacemaker	☐ Heart Trouble/Disease	☐ Hemophilia	☐ Hepatitis A
☐ Hepatitis B or C	☐ Herpes	☐ High Blood Pressure	☐ High Cholesterol
☐ Hives or Rash	☐ Hypoglycemia	☐ Irregular Heartbeat	☐ Kidney Problems
☐ Leukemia	☐ Liver Disease	☐ Low Blood Pressure	☐ Lung Disease
☐ Mitral Valve Prolapse	☐ Multiple Sclerosis	☐ Osteoporosis	☐ Pain in Jaw Joints
☐ Parathyroid Disease	☐ Parkinson's Disease	☐ Psychiatric Care	☐ Radiation Treatments
☐ Recent Weight Loss	☐ Renal Dialysis	☐ Rheumatic Fever	☐ Rheumatism
☐ Scarlet Fever	☐ Shingles	☐ Sickle Cell Disease	☐ Sinus Trouble
☐ Sleep Apnea	☐ Stomach/Intestinal Disease	☐ Stroke	☐ Swelling of Limbs
☐ Thyroid Disease	☐ Tonsillitis	☐ Tuberculosis	☐ Tumors or Growths
☐ Ulcers	☐ Venereal Disease		

Have you ever had any serious illness not listed? ☐ Yes Details if Yes

Further 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: