

Murray Dental Care 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.

Has there been any change in your health in the past two years?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you under a physician's care now? If yes what is the date of your last medical exam?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or have you ever had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a joint replacement (hip, knee), implant, or a cardiac stent? When?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been told to take antibiotic premedication prior to dental appointments?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any over the counter medication including vitamins, aspirin, cold/flu, allergy, herbal?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take anticoagulants or blood thinners?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any prescribed medication?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you used or are you using any recreational drugs, controlled substances, or tobacco products?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you drink alcoholic beverages? What is the frequency per week?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Have you ever taken the following?

<input type="checkbox"/> Phen-Fen	<input type="checkbox"/> Redux	<input type="checkbox"/> Fosamax
<input type="checkbox"/> Boniva	<input type="checkbox"/> Actonel	

Other medications containing bisphosphonates? ☐ If yes

Women Only

Are you...?

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Allergies

Are you allergic to any of the following?

<input type="checkbox"/> Novocaine	<input type="checkbox"/> Xylocaine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Codeine
<input type="checkbox"/> Demerol	<input type="checkbox"/> Valium	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Latex
<input type="checkbox"/> Acrylic			

Other? ☐ If yes

Do you suffer from any of the following?

☐ Seasonal allergies ☐ Hay fever ☐ Sinus problems ☐ Rash
☐ Hives

Do you have now or have you ever had any of the following?

Acid Reflux	<input type="radio"/> Yes <input type="radio"/> No	AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Anorexia Nervosa	<input type="radio"/> Yes <input type="radio"/> No	Angina	<input type="radio"/> Yes <input type="radio"/> No	Anxiety	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No
Blood Clot	<input type="radio"/> Yes <input type="radio"/> No	Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No
Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Bulimia	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Depressive Disorder	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Endocarditis	<input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Excessive/Prolonged Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No
Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches/Migraines	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No
Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Luekemia	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No	Rhematism	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No	Thrombophlebitis	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever had any serous illness not listed?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have any disabilities (hearing, sight, cognitive, speech, walking, MS, cerebral palsy)?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you require any special consideration to accomodate your care?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

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: _____