Fluellen Roberts
FAMILY DENTISTRY

Medical History

Are you under a physician's care now? YES NO _____

Have you ever been hospitalized or had a major operation? YES NO _____

Have you ever had a serious head or neck injury? YES NO _____

Are you taking any medications, pills, or drugs? YES NO _____

Do you take/taken Phen-Fen or Redux? YES NO _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES NO _____

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
- ○ Latex
- ○ Acrylic
- ○ Metal
- ○ Codeine
- ○ Local Anesthetics
- ○ Penicillin
- ○ Sulfa Drugs

Other? IF Yes _____

Do you use controlled substances? YES NO _____

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

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

Have you ever had any serious illness not listed? YES/NO If yes: _____

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 health. It is my responsibility to inform the dental office of any changes in medical status.

X_____Date:_____

Signature of Patient, Parent or Guardian