Dentistry Of Wisconsin – Medical History Form

NAME: **BIRTHDATE:** **DATE:**

Are you currently receiving care with a primary care physician?	◯ Yes ◯ No	If yes	
Have you been hospitalized? Had a major operation? 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		
Do you use controlled substances?	◯ Yes ◯ No	If yes	
Do you use tobacco?	◯ Yes ◯ No	If yes	
Women: are you - pregnant/trying to get pregnant? Taking oral contraceptives? Nursing?	◯ Yes ◯ No	If yes	
Do you currently take a pre-medication prior to dental treatment?	◯ Yes ◯ No	If yes	
Do you have a dental anxiety?	◯ Yes ◯ No	If yes	

Are you allergic to ?

Sulfa	◯ Yes ◯ No	
Latex	◯ Yes ◯ No	
Amoxicillin	◯ Yes ◯ No	
Other Allergies?	◯ Yes ◯ No	If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artifical Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artifical Joint	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Kidney Problems/Disease	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Stomach/Intestinal Problems	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No		
Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Cancer/Leukemia	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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, c
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 re

NO CHANGES in medical history since last visit! ☐

Signature of Patient, Parent or Guardian:

X

Date: