OSBORNE DENTISTRY
MEDICAL HISTORY

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 If yes_____

Do you use tobacco? ◯ Yes ◯ No If yes_____

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

Do you use controlled substances? ◯ Yes ◯ No If yes_____
Other? □ If yes_____

Mark any you have, or have had:

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

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 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: _____