13590 N MERIDIAN ST
SUITE # 101
CARMEL IN 46032

CARMEL COMPREHENSIVE DENTAL CARE

PHONE: (317) 399-5421
PHONE: (317) 575-1995
FAX: (317) 575-1998

MEDICAL HISTORY FORM

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 ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take or have you taken Phen-Fen or Redux? ○ Yes ○ No If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes, please explain: _____
Are you on a special diet? ○ Yes ○ No If yes, please explain: _____
Do you use tobacco? ○ Yes ○ No If yes, please explain: _____
Do you use controlled substances? ○ Yes ○ No If yes, please explain: _____

For Women

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Y ○ N

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ○Y ○N _____

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 _____ DATE _____