Millard Oaks DENTAL
Helping Omaha's Families Smile

MEDICAL HISTORY

Patient name:_____ Date of birth:_____

Although our dental team primarily treats 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 receive. Thank you for answering the following questions.

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

Women: Are you
Pregnant/ Trying to get pregnant? OYes ONo Taking oral contraceptives? OYes ONo Nursing? OYes O No

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

Have you ever had any serious illness not listed above? OYes ONo _____

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 (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:_____