BEACHCREST DENTAL
MEDICAL HISTORY FORM

PATIENT NAME:____ DATE OF BIRTH:____________________ DATE________________

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:____

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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:____

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Have you ever had excessive bleeding after an extraction or do cuts take longer to heal than previously? ___Yes ___No

If Yes:____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ___Yes ___No

If Yes:____

Have you been told you need to premedicate for dental? ___Yes ___No If Yes:____

Do you use tobacco or vape? ___Yes ___No If Yes:____

Do you use controlled substances? ___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

Any other allergies? If yes,____

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

AIDS/HIV Positive	___Yes ___No	Hemophilia	___Yes ___No
Alzheimer's Disease	___Yes ___No	Hepatitis A	___Yes ___No
Anaphylaxis	___Yes ___No	Hepatitis B or C	___Yes ___No
Anemia	___Yes ___No	Herpes	___Yes ___No
Angina	___Yes ___No	High Blood Pressure	___Yes ___No
Arthritis/Gout	___Yes ___No	High Cholesterol	___Yes ___No
Artificial Heart Valve	___Yes ___No	Hives or Rash	___Yes ___No
Artificial Joint	___Yes ___No	Hypoglycemia	___Yes ___No
Asthma	___Yes ___No	Irregular Heartbeat	___Yes ___No
Blood Disease	___Yes ___No	Kidney Problems	___Yes ___No
Blood Transfusion	___Yes ___No	Leukemia	___Yes ___No
Breathing Problems	___Yes ___No	Liver Disease	___Yes ___No
Bruise Easily	___Yes ___No	Low Blood Pressure	___Yes ___No
Cancer	___Yes ___No	Lung Disease	___Yes ___No

Condition	Yes	No
Chemotherapy	___Yes	___No
Chest Pains	___Yes	___No
Cold Sores/Fever Blisters	___Yes	___No
Congenital Heart Disorder	___Yes	___No
Convulsions	___Yes	___No
Yellow Jaundice	___Yes	___No
Cortisone Medicine	___Yes	___No
Diabetes	___Yes	___No
Drug Addiction	___Yes	___No
Easily Winded	___Yes	___No
Emphysema	___Yes	___No
Epilepsy or Seizures	___Yes	___No
Excessive Bleeding	___Yes	___No
Excessive Thirst	___Yes	___No
Fainting Spells/Dizziness	___Yes	___No
Frequent Cough	___Yes	___No
Frequent Diarrhea	___Yes	___No
Frequent Headaches	___Yes	___No
Genital Herpes	___Yes	___No
Glaucoma	___Yes	___No
Hay Fever	___Yes	___No
Heart Attack/Failure	___Yes	___No
Heart Murmur	___Yes	___No
Heart Pacemaker	___Yes	___No
Heart Trouble/Disease	___Yes	___No
Sleep Apnea	___Yes	___No
Mitral Valve Prolapse	___Yes	___No
Osteoporosis	___Yes	___No
Pain in Jaw Joints	___Yes	___No
Parathyroid Disease	___Yes	___No
Psychiatric Care	___Yes	___No
Radiation Treatments	___Yes	___No
Recent Weight Loss	___Yes	___No
Renal Dialysis	___Yes	___No
Rheumatic Fever	___Yes	___No
Rheumatism	___Yes	___No
Scarlet Fever	___Yes	___No
Shingles	___Yes	___No
Sickle Cell Disease	___Yes	___No
Sinus Trouble	___Yes	___No
Spina Bifida	___Yes	___No
Stomach/Intestinal Disease	___Yes	___No
Stroke	___Yes	___No
Swelling of Limbs	___Yes	___No
Thyroid Disease	___Yes	___No
Tonsillitis	___Yes	___No
Tuberculosis	___Yes	___No
Tumors or Growths	___Yes	___No
Ulcers	___Yes	___No
Venereal Disease	___Yes	___No

Have you ever had any serious illness not listed above? ___Yes ___No If Yes:____

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Any additional 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 Beachcrest Dental of any changes in medical status.

Signature of Patient, Parent or Guardian:

X____Date:________________________________