SODINI
DENTAL

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Medical History Form

Patient Name:________________________________ **DOB:**________________

Are you under a physician's care now?	☐ Yes ☐ No If yes, ____________
Have you even 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, drugs or supplements?	☐ 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, ____________
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
☐ Other If yes, please explain: ____________

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, ____________

Comments: ____________

To the best of my knowledge, the questions on this form hav been accurately answered. I understand that providing the 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:**________