PIONEER DENTAL GROUP

Medical History

Patient Name (Please Print) _____ Birth Date _____

Although dental personnel primarily treat the area on and around your mouth, your mouth is a part of your entire body. Health problems that your may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? YES NO If yes, explain _____
Have you ever been hospitalized/had a major operation? YES NO If yes, explain _____
Have you ever had a serious head or neck injury? YES NO If yes, explain _____
Are you taking any medications, pills, or drugs*? YES NO If yes, explain _____
Do you take, or have you taken, Phen-Fen or Redux? YES NO If yes, explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES NO If yes, explain _____
Are you on a special diet? YES NO If yes, explain _____
Do you use tobacco? YES NO If yes, explain _____
Do you drink alcohol? YES NO If yes, how much:_____
Do you use controlled substances? YES NO If yes, explain _____

WOMEN: Are you pregnant/trying to get pregnant? YES NO Est. Due Date: _____ Nursing YES NO
Are you taking oral contraceptives? YES NO

Are you allergic to any of the following?
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other NO KNOWN ALLERGIES

Please explain: _____

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

AIDS/HIV Positive	YES	NO	Convulsions	YES	NO	Heart Pacemaker	YES	NO	Pain in Jaw Joints	YES	NO
Alzheimer's Disease	YES	NO	Cortisone Medicine	YES	NO	Heart Trouble/Disease	YES	NO	Parathyroid Disease	YES	NO
Anemia	YES	NO	Diabetes	YES	NO	Hemophilia	YES	NO	Psychiatric Care	YES	NO
Angina	YES	NO	Drug Addiction	YES	NO	Hepatitis A	YES	NO	Radiation Treatments	YES	NO
Arthritis/Gout	YES	NO	Easily Winded	YES	NO	Hepatitis B or C	YES	NO	Recent Weight Loss	YES	NO
Artificial Heart Valve	YES	NO	Emphysema	YES	NO	High Blood Pressure	YES	NO	Renal Dialysis	YES	NO
Artificial Joint	YES	NO	Epilepsy & Seizures	YES	NO	High Cholesterol	YES	NO	Rheumatic Fever	YES	NO
Asthma	YES	NO	Excessive Bleeding	YES	NO	Hives or Rash	YES	NO	Rheumatism	YES	NO
Blood Disease	YES	NO	Excessive Thirst	YES	NO	Hypoglycemia	YES	NO	Shingles	YES	NO
Blood Transfusion	YES	NO	Fainting /Dizziness	YES	NO	Irregular Heartbeat	YES	NO	Sickle Cell Disease	YES	NO
Breathing Problem	YES	NO	Frequent Cough	YES	NO	Kidney Problems	YES	NO	Sinus Trouble	YES	NO
Bruise Easily	YES	NO	Frequent Headaches	YES	NO	Leukemia	YES	NO	Stomach/Intestinal Disease	YES	NO
Cancer	YES	NO	Genital Herpes	YES	NO	Liver Disease	YES	NO	Stroke	YES	NO
Chemotherapy	YES	NO	Glaucoma	YES	NO	Low Blood Pressure	YES	NO	Swelling of Limbs	YES	NO
Chest Pains	YES	NO	Hay Fever	YES	NO	Lung Disease	YES	NO	Thyroid Disease	YES	NO
Cold Sores/Fever Blisters	YES	NO	Heart Attack/Failure	YES	NO	Mitral Valve Prolapse	YES	NO	TB or Respiratory Disease	YES	NO
Congenital Heart Disorder	YES	NO	Heart Murmur	YES	NO	Osteoporosis	YES	NO	Yellow Jaundice	YES	NO

Have you ever had any serious illness not listed above? YES NO Explain:
_____

**If you have any additional medications you may list them on the back of the form. A copy can be scanned into your chart.*

Signature of Patient, Parent, Guardian _____ Date _____

Doctor Signature _____ Date _____