Thane B. Anderson DDS Medical History Form

PATIENT NAME _____ Birth Date _____

Address _____ Phone _____

E-mail _____ Cell Phone _____

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. All responses will remain confidential.

Physician's name, address and phone: _____

Medical Insurance: _____

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,
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,
Have you ever taken Foxamax, Boniva, Actonel or any other medications containing bisohosphonates?	○ 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?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergies, not listed above ○ Yes ○ No If yes _____

Pre-Medication Requirement
Do you require pre-medication ○ Yes ○ No If yes _____

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

☐ Acid Reflux/GERD	☐ AIDS/HIV Positive	☐ Alzheimer's Disease	☐ Anaphylaxis
☐ Anemia	☐ Angina	☐ Arthritis/Gout	☐ Artificial Joint
☐ Asthma	☐ Blood Disease	☐ Breathing Problem	☐ Bruise Easily
☐ Cancer	☐ Chemotherapy	☐ Chest Pain	☐ Cholesterol – High/Low
☐ Cold Sores/Fever Blisters	☐ Convulsions	☐ Cortisone Medicine	☐ Diabetes
☐ Drug Addiction	☐ Easily Winded	☐ Emphysema	☐ Epilepsy or Seizures
☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting Spells/Dizziness	☐ Frequent Cough
☐ Frequent Headaches	☐ Glaucoma	☐ Hay Fever	☐ Heart Attack/Failure
☐ Heart-Artificial Valve	☐ Heart – Congen. Disord	☐ Heart – Irregular Beat	☐ Heart Murmur
☐ Heart Pace Maker/ICD	☐ Heart Stents	☐ Hemophilia	☐ Hepatitis A
☐ Hepatitis B or C	☐ High Blood Pressure	☐ Hives or Rash	☐ Hypoglycemia
☐ Kidney Problems	☐ Leukemia	☐ Liver Disease	☐ Low Blood Pressure
☐ Lung Disease	☐ Mitral Valve Prolapse	☐ Pain in Jaw Joints	☐ Parathyroid Disease
☐ Psychiatric Care	☐ Radiation Treatments	☐ Recent Weight Loss	☐ Renal Dialysis
☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever	☐ Shingles
☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Spina Bifida	☐ Stomach/Intestinal Disease
☐ Stroke	☐ Swelling of Limbs	☐ Thyroid Disease	☐ Tonsillitis
☐ Tumors or Growths	☐ Ulcers	☐ Yellow Jaundice	☐

Have you ever had a serious illness not listed? ○ Yes ○ No If yes _____

Additional info on Meds List:

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 _____

KJA Rev 8/7/17