Cedarburg Family Dentistry/CFD Medical History

Patient Name: **Birth Date:** **Date Created:**

Are you under a physician's care now? If yes, who is your doctor?	□ YES □ NO	If yes
Have you ever been hospitalized or had a major operation in the last 7 years?	□ YES □ NO	If yes
Have you ever had a serious head or neck injury?	□ 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
Do you require pre-medication prior to your dental appointment?	□ YES □ NO	If yes
Do you have a preferred pharmacy?	□ YES □ NO	If yes
Are you taking any medications, pills, or drugs? If yes, please list below.	□ YES □ NO	

Do you feel pain in any of your teeth or pertaining to your head/neck area? □ YES □ NO

Allergies: Do you have any of the following? (If none, please check "NONE')

□ Aspirin	□ Penicillin	□ Codeine	□ Acrylic
□ Metal/Nickel	□ Latex	□ Sulfa Drugs	□ Local Anesthetics
□ Iodine	□ **NONE**		

Other? □ If yes

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FOR WOMEN: Are you…

□ Pregnant/Trying to get pregnant? □ Nursing? □ Taking oral contraceptives?

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

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

Have you ever had any serious illness not listed above? □ YES □ NO

If yes:

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:

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