MVP Dental

"Your Smile is Our Passion"

MEDICAL HISTORY

Patient Name: _____ **Birth Date:** _____

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

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

Explain: Yest here you go

Are you allergic to any of the following?

Aspirin		Acrylic	
Penicillin		Metal	
Codeine		Latex	
Local Anesthetics		Sulfa Drugs	

Other

If yes, please explain:

- **Are you under a physician's care now? Y/N**

If yes, please explain: _____

- **Have you ever been hospitalized or had a major operation? Y/N**

If yes, please explain: _____

- **Have you ever had a serious head or neck injury? Y/N**

If yes, please explain: _____

- **Are you taking any medications, pills, or drugs? Y/N**

If yes, please explain: _____

- **Do you take, or have you taken, Phen-Fen or Redux? Y/N**

If yes, please explain: _____

- **Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y/N**

If yes, please explain: _____

Women, are you:

Pregnant/Trying to get pregnant? **Y** **N**

Taking oral contraceptives? **Y** **N**

Nursing? **Y** **N**

Are you on a special diet?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances?	Yes	No

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 my 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_____