Pacific Park
Family Dental

Medical History

Are you under a physician's care at the moment?	○ 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:
Do you take / have 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:

Woman: ☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal Latex ○ Sulfa Drugs
○ Local Anesthetic ○ Other? _____
Do you use any controlled? ○ Yes ○ No

Please circle all that apply:

AIDS / HIV Positive
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis / Gout
Artificial Heart Valve
Asthma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores / Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spell / Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack / Failure
Heart Murmur
Heart Pacemaker
Heart Trouble / Disease
Hemophilia
Hepatitis A B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain
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
Tobacco Use
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed? If yes, please explain: _____

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 health. It is my responsibility to inform the dental office of any changes in my medical status.

Patient signature / Responsible Party: _____ Date: _____
Relationship to patient: _____