MELINDA BECK DDS
GENERAL • COSMETIC • SENIOR CARE

Medical History

Patient Name _____ DOB _____
Please Print First Middle Initial Last mm / dd / yyyy

Physician _____ Physician Phone _____

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

☐ Yes ☐ No Are you under a physician's care now? If yes, please explain: _____

☐ Yes ☐ No Have you ever been hospitalized or had a major operation? If yes, please explain: _____

☐ Yes ☐ No Are you taking any medications, pills or drugs? If yes, please list current medications: _____

_____

☐ Yes ☐ No Do you take, or have you taken, Phen-Fen or Redux?

☐ Yes ☐ No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

☐ Yes ☐ No Are you on a special diet?

☐ Yes ☐ No Do you use tobacco?

☐ Yes ☐ No Do you use controlled substances?

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex
☐ Sulfa drugs ☐ Other If yes, please explain _____

Do you have, or have you had, any of the following? Please circle correct response.

AIDS/HIV Positive	Yes	No	Cold Sores/Fever Blisters	Yes	No	Glaucoma	Yes	No
Alzheimer's Disease	Yes	No	Congenital Heart Disorder	Yes	No	Hay Fever	Yes	No
Anaphylaxis	Yes	No	Convulsions	Yes	No	Heart Attack/Failure	Yes	No
Anemia	Yes	No	Cortisone Medication	Yes	No	Heart Murmur	Yes	No
Angina	Yes	No	Diabetes	Yes	No	Heart Pacemaker	Yes	No
Arthritis/Gout	Yes	No	Drug Addiction	Yes	No	Heart Trouble/Disease	Yes	No
Artificial Heart Valve	Yes	No	Easily Winded	Yes	No	Hemophilia	Yes	No
Artificial Joint	Yes	No	Emphysema	Yes	No	Hepatitis A	Yes	No
Asthma	Yes	No	Epilepsy or Seizures	Yes	No	Hepatitis B or C	Yes	No
Blood Disease	Yes	No	Excessive Bleeding	Yes	No	Herpes	Yes	No
Blood Transfusion	Yes	No	Excessive Thirst	Yes	No	High Blood Pressure	Yes	No
Breathing Problem	Yes	No	Fainting Spells/Dizziness	Yes	No	High Cholesterol	Yes	No
Bruise Easily	Yes	No	Frequent Cough	Yes	No	Hives or Rash	Yes	No
Cancer	Yes	No	Frequent Diarrhea	Yes	No	Hypoglycemia	Yes	No
Chemotherapy	Yes	No	Frequent Headaches	Yes	No	Irregular Heartbeat	Yes	No
Chest Pains	Yes	No	Genital Herpes	Yes	No	Kidney Problems	Yes	No

Leukemia	Yes	No	Recent Weight Loss	Yes	No	Swelling of Limbs	Yes	No
Liver Disease	Yes	No	Renal Dialysis	Yes	No	Thyroid Disease	Yes	No
Low Blood Pressure	Yes	No	Rheumatism	Yes	No	Tonsillitis	Yes	No
Lung Disease	Yes	No	Scarlet Fever	Yes	No	Tuberculosis	Yes	No
Mitral Valve Prolapse	Yes	No	Shingles	Yes	No	Tumors or Growths	Yes	No
Osteoporosis	Yes	No	Sickle Cell Disease	Yes	No	Ulcers	Yes	No
Pain in Jaw Joints	Yes	No	Sinus Trouble	Yes	No	Venereal Disease	Yes	No
Parathyroid Disease	Yes	No	Spina Bifida	Yes	No	Yellow Jaundice	Yes	No
Psychiatric Care	Yes	No	Stomach/Intestinal Disease	Yes	No			
Radiation Treatments	Yes	No	Stroke	Yes	No			

Have you ever had any serious illness not listed above? Yes No

Comments: _____

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 Legal Guardian _____ Date _____

(For Digital forms your printed name acts as your signature)

FOR OFFICE USE ONLY

History has been reviewed and verified by the doctor. All questions and concerns have been answered.

Signature _____ Date _____