Southwest Dental Associates

Helen H. Harless, D.D.S., F.A.G.D.

Medical History

Name _____ Birth Date ____/____/____

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

Ever been hopitalized or had a major operation? Yes ☐ No ☐ If Yes, explain _____

Have you ever had a serious head or neck injury? Yes ☐ No ☐ If Yes, explain _____

Are you taking any medication, pills, or drugs? Yes ☐ No ☐ If Yes, explain _____

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

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

Are you on a special diet? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐

Women: Are you pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐

Are you allergic to any of the following:

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐

Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐

Allergic to anything else? _____

Do you use any controlled substances? Yes ☐ No ☐ If Yes, explain _____

Do you have **now**, or have you **had**, any of the following:

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

Have you had any serious illness not listed? Yes ☐ No ☐ If Yes, explain _____

Please comment on: _____

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 medical status.

Signed _____ Date _____

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