NORTH STAR DENTISTRY

Medical History

Patient Name: _____

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

Are you taking any prescription or over the counter medications? YES / NO

if yes, please list _____

_____

Do you take a blood thinner? (such as Aspirin, Coumadin, Plavix) YES / NO

DO YOU HAVE ANY OF THE FOLLOWING?

___ Abnormal Bleeding	___ Epilepsy/Seizures	___ Kidney Problems	___ Sinus Problems
___ AIDS/HIV	___ Fainting Spells	___ Liver Disease	___ Skin Rash
___ Anemia	___ Fever Blisters/Cold Sores	___ Low Blood Pressure	___ Substance Abuse
___ Arthritis/Rheumatism	___ Glaucoma	__ Mitral Valve Prolapse	___ Swelling of Feet or Ankles
___ Artificial Heart Valves	___ Heart Attack/Stroke	___ Nervous Problems	___ Swollen Neck Glands
___ Artificial Joints	___ Heart Murmur	___ Pace Maker	___ Thyroid Problems
___ Asthma	___ Heart Problems	___ Radiation to Head/neck	___ Tonsillitis
___ Blood Transfusion	___ Heart Surgery	___ Respiratory Disease	___ Tuberculosis
___ Cancer/Chemo/Radiation	___ Hemophilia	___ Rheumatic Fever	___ Ulcers/Colitis
___ Congenital Heart Defect	___ Hepatitis, Type ___	___ Scarlet Fever	___ Venereal Disease
___ Depression	___ Herpes I or II	___ Severe/Freq Headaches	
___ Diabetes, Type ____	___ High Blood Pressure	___ Shingles	
___ Emotional/Mental Disorder	___ Jaundice	___ Shortness of Breath	
___ Emphysema	___ Jaw Pain	___ Sleep Apnea	

Have you had any serious illness not listed above? YES / NO / NA _____

***WOMEN ONLY*: Are you pregnant or is there a chance you may be pregnant? YES / NO Are you nursing? YES / NO**

Are you taking oral contraceptives? YES / NO

ALLERGIES: ARE YOU ALLERGIC TO OR SENSITIVE TO ANY OF THE FOLLOWING?

___ Latex ___ Erythromycin ___ Codeine ___ Sulfa ___ Penicillin ___ Aspirin ___ Epinephrine ___Lactose ___ Other _____