PRAIRIE LAKES DENTAL P.A.

MEDICAL HISTORY

Are you under a physician's care now? Yes/No Explain_____

Physician's Name and Location_____

Have you ever been hospitalized or had a major operation? Yes/No Explain_____

Have you ever had a serious head/neck injury? Yes/No Explain_____

Are you taking any medications, vitamins, supplements? List _____

_____

Have you ever taken Phen-Fen, Redux, Fosamax, Boniva, Actonel, or Zometa? Yes/No

Do you use tobacco? Yes/No Type_____ Quantity_____

Do you take any controlled substances? Yes/No Type_____

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Antibiotics
Other_____

Have you been told to take an antibiotic prior to your dental treatment? Yes/No_____

Are you pregnant? Yes/No Breastfeeding? Yes/No Taking oral contraceptives? Yes/No

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

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

Do you have any condition or disease not mentioned above? Yes/No

Comments_____

Print Patient Name_____

Patient/Responsible Party Signature_____Date_____

To the best of my knowledge, the answers 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.