Black Hills Area Dental Medical History

PATIENT NAME _____ **Birth Date** _____

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 under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please LIST ALL: _____
Do you use tobacco (including e-cigs): If so, What?	Yes	No	How packs/cigs per day/week_____
Do you consume alcohol?	Yes	No	If yes, how many beverages per week? _____
Do you snore or have you ever been told you snore?	Yes	No	
Have you ever had a sleep study? Or been told to get one?	Yes	No	If so when: _____
Do you wear a C-PAP or have you been told to?	Yes	No	If yes, how long have you been using it_____

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? Please Circle.

Acetaminophen **Codeine** **Latex** **Penicillin** **Acrylic** **Fluoride** **Local Anesthetics**
Sulfa Drugs **Aspirin** **Ibuprofen** **Metal**

Other allergies, If yes, please explain: _____

Do you or have you taken any of the following?

Antiacids	Yes	No
Barbiturates (sleeping sedatives)	Yes	No
Dilantin or Tegretol	Yes	No
St John's Wart or Kava Kava	Yes	No

Please list any other conditions or concerns:

_____

_____

_____

_____

(Please see other side)

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

Acid Reflux	Yes	No	**Depression**	Yes	No	**Hepatitis B or C**	Yes	No	**Recent Weight Loss**	Yes	No
AIDS/HIV positive	Yes	No	**Diabetes Type 1**	Yes	No	**High Blood Pressure**	Yes	No	**Recent Weight Loss**	Yes	No
Alzheimer's Disease	Yes	No	**Diabetes Type 2**	Yes	No	**High Cholesterol**	Yes	No	**Renal Dialysis**	Yes	No
Anaphylaxis	Yes	No	**Insulin Pump**	Yes	No	**Infective Endocarditis**	Yes	No	**Rheumatic Fever**	Yes	No
Anemia	Yes	No	**Drug Addiction**	Yes	No	**Hives or Rash**	Yes	No	**Rheumatism**	Yes	No
Angina	Yes	No	**Emphysema**	Yes	No	**Hypoglycemia**	Yes	No	**Scarlet Fever**	Yes	No
Arthritis/Gout	Yes	No	**Epilepsy or Seizures**	Yes	No	**Insomnia**	Yes	No	**Shingles**	Yes	No
Artificial Heart Valve	Yes	No	**Excessive Bleeding**	Yes	No	**Irregular Heartbeat**	Yes	No	**Sinus Trouble**	Yes	No
Artificial Joint	Yes	No	**Excessive Thirst**	Yes	No	**Kidney Problems**	Yes	No	**Sleep Apnea**	Yes	No
Asthma	Yes	No	**Fainting/Dizziness**	Yes	No	**Leukemia**	Yes	No	**Spina Bifida**	Yes	No
Blood Disease	Yes	No	**Fibromyalgia**	Yes	No	**Liver Disease**	Yes	No	**Stomach Disease**	Yes	No
Blood Transfusion	Yes	No	**Frequent Cough**	Yes	No	**Low Blood Pressure**	Yes	No	**Stroke**	Yes	No
Breathing Problem	Yes	No	**Frequent Diarrhea**	Yes	No	**Lumps or Swelling**	Yes	No	**Swelling of Limbs**	Yes	No
Bruise Easily	Yes	No	**Frequent Headaches**	Yes	No	**Lung Disease**	Yes	No	**Thyroid Disease**	Yes	No
Calcium Deficiency	Yes	No	**Genital Herpes**	Yes	No	**Mitral Valve Prolapse**	Yes	No	**Tonsilitis**	Yes	No
Cancer	Yes	No	**Glaucoma**	Yes	No	**Neuro Disorder (ADD)**	Yes	No	**Trouble Sleeping**	Yes	No
Chemotherapy	Yes	No	**Hay Fever/Allergies**	Yes	No	**Osteopenia (Bisphos)**	Yes	No	**Tuberculosis**	Yes	No
Chest Pains	Yes	No	**Heart Attack/Failure**	Yes	No	**Osteoporosis**	Yes	No	**Tumors or Growths**	Yes	No
Cold Sores/Blisters	Yes	No	**Heart Murmur**	Yes	No	**Pain in Jaw**	Yes	No	**Ulcers**	Yes	No
Congenital Heart Defect	Yes	No	**Heart Pacemaker**	Yes	No	**Parathyroid Disease**	Yes	No	**Warfarin/Coumadin**	Yes	No
Contact Lenses	Yes	No	**Heart Trouble/Disease**	Yes	No	**Prolonged Bleeding**	Yes	No			
Convulsions	Yes	No	**Hemophilia**	Yes	No	**Psychiatric Care**	Yes	No			
Cortisone Medicine	Yes	No	**Hepatitis A**	Yes	No	**Radiation Treatment**	Yes	No			

Have you ever had any serious illness not listed above? Yes No **If yes, please explain:**

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____