

McDuffie In-Home Dental Care

Medical History Form

Patient Information

Patient Name: _____

Date of Birth: _____

Date Completed: _____

Medical Status

Although dental treatment primarily involves the mouth, oral health is directly related to overall health. Please answer all questions completely. Providing accurate information is essential for your safety.

1. Are you under a physician's care now?

Yes No

If yes, explain: _____

2. Have you ever been hospitalized or had a major operation?

Yes No

If yes, explain: _____

3. Have you ever had a serious head or neck injury?

Yes No

If yes, explain: _____

4. Are you taking any medications, pills, or drugs?

Yes No

If yes, list: _____

5. Do you take, or have you taken, Phen-Fen or Redux?

Yes No

If yes, explain: _____

6. Have you ever taken Fosamax, Boniva, Actonel, or other medications containing bisphosphonates?

Yes No

If yes, explain: _____

7. Are you on a special diet?

Yes No

8. Do you use tobacco?

Yes No

9. Do you use controlled substances?

Yes No

If yes, explain: _____

Women Only

Pregnant / Trying to get pregnant

Nursing

Taking oral contraceptives

Allergies

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa drugs

Local anesthetics

Other allergies: _____

Medical Conditions

Do you have, or have you ever had, any of the following?
(Check Yes or No for each.)

Condition	Yes	No
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Gout	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores / Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>

Condition	Yes	No
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells / Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack / Failure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble / Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>

Condition	Yes	No
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>

Condition	Yes No	
Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Stomach / Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>

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 professionals of any changes in medical status.

Signature of Patient or Guardian: _____