NEW ORLEANS DENTAL CENTER
Medical History

Patient Name_____ Birth Date_____ Date Created_____

Please be aware that a patient's health problems, or medication that is taken, could have an important interrelationship with the dental care received.

Are you under a physician's care now? □Yes □No If yes _____

Have you been hospitalized or had a major operation, other than childbirth? □Yes □No If yes _____

Have you ever had a serious head or neck injury? □Yes □No If yes _____

Are you taking any medications—either prescriptions or over-the-counter, including herbals? □Yes □No If yes _____

Have you ever taken Fosamax, Boniva, or any other medications containing bisphosphonates? □Yes □No If yes _____

Have you ever been told to take antibiotics prior to dental treatment regarding heart or joint protection? □Yes □No If yes _____

Have you had eye surgery in the past 8 weeks? □Yes □No If yes _____

Do you use tobacco or controlled substances? □Yes □No If yes _____

Are you nervous about dental treatment? □Yes □No If yes _____

Women: Are you…

□ Pregnant/Trying to become pregnant? □ Nursing? □ Taking oral contraceptives?

Are you allergic or sensitive to any of the following?

□ Acrylic □ Codeine □ Latex □ Local Anesthetics

□ Metal (nickel, stainless steel) □ Penicillin □Sulfa Drugs □ NO KNOWN ALLERGIES

Any other allergies or sensitivities? □Yes □No If yes _____

Emergency Contact Person(s)/Comments:

Please check "yes" if you currently have, or you've previously had, any of the following:

AIDS/HIV Positive	□Yes □No	Cortisone/Steroid Medicine	□Yes □No	Herpes	□Yes □No	Psychiatric Care	□Yes □No
Alzheimer's Disease	□Yes □No	Diabetes	□Yes □No	High Blood Pressure	□Yes □No	Radiation Treatment	□Yes □No
Anaphylaxis	□Yes □No	Drug Addiction	□Yes □No	High Cholesterol	□Yes □No	Renal Dialysis	□Yes □No
Anemia	□Yes □No	Emphysema/COPD	□Yes □No	Hives/Rashes	□Yes □No	Restless Leg Syndrone	□Yes □No
Angina	□Yes □No	Environmental Allergies	□Yes □No	Hypoglycemia	□Yes □No	Rheumatic Fever	□Yes □No
Arthritis	□Yes □No	Epilepsy	□Yes □No	Irregular Heartbeat	□Yes □No	Scarlet Fever	□Yes □No
Artificial Heart Valve	□Yes □No	Excessive Bleeding	□Yes □No	Jaundice	□Yes □No	Shingles	□Yes □No
Artificial Joint	□Yes □No	Excessive Thirst	□Yes □No	Kidney Problems/Disease.	□Yes □No	Sickle Cell Disease	□Yes □No
Asthma	□Yes □No	Fainting/Dizziness	□Yes □No	Leukemia	□Yes □No	Sinus Problems	□Yes □No
Blood Disease	□Yes □No	Frequent Cough	□Yes □No	Lichen Planus	□Yes □No	Sleep Apnea	□Yes □No
Blood Transfusion	□Yes □No	Frequent Diarrhea	□Yes □No	Liver Disease	□Yes □No	Stomach/Intestinal Disease	□Yes □No
Breathing Problems	□Yes □No	Frequent Headaches	□Yes □No	Low Blood Pressure	□Yes □No	Stroke/TIAs	□Yes □No
Bruise Easily	□Yes □No	Glaucoma	□Yes □No	Lung Disease	□Yes □No	Swelling of Limbs/Face	□Yes □No
Cancer	□Yes □No	Heart Attack/Failure	□Yes □No	Lupus Erythematosus	□Yes □No	Thyroid Disease	□Yes □No
Chemotherapy	□Yes □No	Heart Murmur	□Yes □No	Mitral Valve Prolapse	□Yes □No	Tonsillitis	□Yes □No
Chest Pains	□Yes □No	Heart Pacemaker	□Yes □No	Osteoporosis/Osteopenia	□Yes □No	Tuberculosis	□Yes □No
Cold Sores/Fever Blisters	□Yes □No	Heart Trouble/Disease	□Yes □No	Pain in Jaws/TMJ Problems	□Yes □No	Tumor ors or Growths	□Yes □No
Congenital Heart Disorder	□Yes □No	Hemophilia	□Yes □No	Parathyroid Disease	□Yes □No	Ulcers (gastrointestinal)	□Yes □No
Convulsions or Seizures	□Yes □No	Hepatitis	□Yes □No				

Have you had any condition not listed above? □Yes □No If yes _____

To the best of my knowledge, the questions on this form have been accurately and completely answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. I agree that it is my responsibility to inform New Orleans Dental Center of any changes in my/the patient's medical status.

Signature of Patient, Parent, or Guardian:

X_____ Date_____