Jeffery Spilman D.D.S.

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 explain:_____
Are you taking any medications? ○Yes ○No explain:_____
Have you ever taken Fosamax, Boniva, or Actonel? ○Yes ○No explain:_____
Do you use tobacco? ○Yes ○No explain:_____
Do you use controlled substances? ○Yes ○No explain:_____
Are you taking blood thinners? ○Yes ○No explain:_____

Women: Are you
- ☐ Pregnant/trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	☐	Acrylic	☐	Other: _____
Penicillin	☐	Metal	☐	_____
Codeine	☐	Sulfa Drugs	☐	_____
Latex	☐	Local anesthetic	☐	

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

☐ Aids/HIV Positive	☐ Emphysema	☐ High Blood Pressure	☐ Sinus Trouble
☐ Alzheimer's Disease	☐ Epilepsy or Seizures	☐ Irregular Heartbeat	☐ Stomach/Intestinal Disease
☐ Anemia	☐ Excessive Bleeding	☐ Kidney Problems	☐ Stroke
☐ Angina	☐ Fainting/Dizziness	☐ Liver Disease	☐ Thyroid Disease
☐ Artificial Heart Valve	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Ulcers
☐ Artificial Joint	☐ Genital Herpes	☐ Lung Disease	☐ Venereal Disease
☐ Asthma	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Yellow Jaundice
☐ Blood Disease	☐ Hay Fever	☐ Osteoporosis	
☐ Breathing Problem	☐ Heart Murmur	☐ Psychiatric Care	Any serious illness not listed?
☐ Cancer	☐ Heart Pacemaker	☐ Recent Weight Loss	☐ Yes
☐ Cold Sores/Fever Blisters	☐ Heart trouble/Disease	☐ Rheumatic Fever	☐ No
☐ Convulsions	☐ Hemophilia	☐ Rheumatism	If yes, please explain_____
☐ Diabetes	☐ Hepatitis A, B or C	☐ Scarlet Fever	_____
☐ Drug Addiction	☐ Herpes	☐ Shingles	_____

Comments: _____

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 office of any changes in medical status.

Signature of Patient, Parent, or Guardian_____Date: _____