Lux Dental
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Lux Dental

MEDICAL HISTORY

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 medication, pills, or drugs? □ Yes □ No If yes, please explain_____

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

Do you use tobacco? □ Yes □ No

Do you use controlled substances? □ Yes □ No

WOMEN: Are You
□ Pregnant/ Trying to get pregnant?
□ Nursing?
□ Taking oral contraceptives?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Sulfa Drugs □ Other

If yes, please explain: _____

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

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

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 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 _____