Time 9:49 AM | Denali Dental Associates, LLC | Date 11/17/2016

New Medical History Form

Patient Name: Birth Date: Date Created:

Please answer the following questions regarding any health issues or medications you may be taking. Thank you.

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco or any controlled substances? Frequency?	◯ Yes ◯ No	If yes
History of substance abuse or addiction?	◯ Yes ◯ No	If yes

Women: Are you...

- ☐ Pregnant/Weeks along________
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine
☐ Acrylic	☐ Metal	☐ Latex
☐ Sulfa Drugs	☐ Local Anesthetics	☐ Seasonal/food
☐ Other Allergies: ____________________		

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

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

☐ AIDS/HIV Positive	☐ Congenital Heart Disorder	☐ Hepatitas A	☐ Psychiatric Care
☐ Alzheimer's Disease	☐ Cortisone Medicine	☐ Hepatitis B or C	☐ Radiation Treatments
☐ Anaphylaxis	☐ Diabetes	☐ Herpes	☐ Rheumatic Fever
☐ Anemia	☐ Easily Winded	☐ High Blood Pressure	☐ Rheumatism
☐ Angina	☐ Emphysema	☐ High Cholesterol	☐ Reflux / GERD
☐ Arthritis / Gout	☐ Epliepsy or Seizures	☐ Hives or Rash	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Asthma	☐ Fainting spells / Dizziness	☐ Kidney Problems	☐ Stomach / Intestinal Disease
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Transfusion	☐ Frequent Headaches	☐ Liver Disease	☐ Thyroid Disease
☐ Bruise Easily	☐ Glaucoma	☐ Low Blood Pressure	☐ Tuberculosis
☐ Cancer	☐ Heart Attack / Failure	☐ Mitral Valve Prolapse	☐ Tumors or Growths
☐ Chemotherapy	☐ Heart Murmur	☐ Osteoporosis	☐ Ulcers
☐ Chest Pains	☐ Heart Pacemaker	☐ Pain in Jaw Joint	☐ Recent Weight Loss
☐ Cold Sores / Fever Blisters	☐ Heart Trouble / Disease	☐ Parathyroid Disease	

Question	Answer	
Have you had any serious illness not listed?	◯ Yes ◯ No	If yes
Do you have dental anxiety? Please describe	◯ Yes ◯ No	If yes

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:

X Date:___________