FABRE FAMILY DENTAL CARE OF MARRERO
MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

DISCLAIMER:
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?	O Yes	O No	If yes:	
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes:	
Have you ever had a serious head or neck injury?	O Yes	O No	If yes:	
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes:	
Do you take blood thinners?	O Yes	O No	If yes:	
Have you ever taken Fosamax, Boniva, Actonel, any other medications containing bisphosphonates?	O Yes	O No	If yes:	
Do you use tobacco?	O Yes	O No	If yes:	
Do you use controlled substances?	O Yes	O No	If yes:	

WOMEN: Are you…
☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Clindamycin
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	☐ Other:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Acid Reflux	O Yes	O No	Easily Winded	O Yes	O No	Low Blood Pressure	O Yes	O No
AIDS/HIV Positive	O Yes	O No	Emphysema	O Yes	O No	Lung Disease	O Yes	O No
Alzheimer's Disease	O Yes	O No	Epilepsy or Seizures	O Yes	O No	Mitral Valve Prolapse	O Yes	O No
Anaphylaxis	O Yes	O No	Excessive Bleeding	O Yes	O No	Osteoporosis	O Yes	O No
Anemia	O Yes	O No	Excessive Thirst	O Yes	O No	Pain in Jaw Joints	O Yes	O No
Angina	O Yes	O No	Fainting Spells/Dizziness	O Yes	O No	Parathyroid Disease	O Yes	O No
Anxiety/ Panic Attacks	O Yes	O No	Frequent Cough	O Yes	O No	Psychiatric Care	O Yes	O No
Arthritis/Gout	O Yes	O No	Frequent Headaches	O Yes	O No	Radiation Treatments	O Yes	O No
Artificial Heart Valve	O Yes	O No	Genital Herpes	O Yes	O No	Renal Dialysis	O Yes	O No
Artificial Joint	O Yes	O No	Glaucoma	O Yes	O No	Rheumatic Fever	O Yes	O No
Asthma	O Yes	O No	Heart Attack/Failure	O Yes	O No	Rheumatism	O Yes	O No
Blood Disease	O Yes	O No	Heart Murmur	O Yes	O No	Scarlet Fever	O Yes	O No
Blood Transfusion	O Yes	O No	Heart Pacemaker	O Yes	O No	Shingles	O Yes	O No
Breathing Problems	O Yes	O No	Heart Trouble/Disease	O Yes	O No	Sickle Cell Disease	O Yes	O No
Bruise Easily	O Yes	O No	Hemophilia	O Yes	O No	Sinus Trouble	O Yes	O No
Cancer	O Yes	O No	Hepatitis A	O Yes	O No	Spina Bifida	O Yes	O No
Chemotherapy	O Yes	O No	Hepatitis B or C	O Yes	O No	Stomach/Intestinal Disease	O Yes	O No
Chest Pains	O Yes	O No	Herpes	O Yes	O No	Stroke	O Yes	O No
Cold Sores/Fever Blisters	O Yes	O No	High Blood Pressure	O Yes	O No	Swelling of Limbs	O Yes	O No
Congenital Heart Disorder	O Yes	O No	High Cholesterol	O Yes	O No	Thyroid Disease	O Yes	O No
Convulsions	O Yes	O No	Hives or Rash	O Yes	O No	Tonsillitis	O Yes	O No
Cortisone Medicine	O Yes	O No	Hypoglycemia	O Yes	O No	Tuberculosis	O Yes	O No
Diabetes	O Yes	O No	Irregular Heartbeat	O Yes	O No	Tumors or Growths	O Yes	O No
Diverticulitis	O Yes	O No	Kidney Problems	O Yes	O No	Ulcers	O Yes	O No
Drug Addiction	O Yes	O No	Leukemia	O Yes	O No	Venereal Disease	O Yes	O No
Eating Disorder	O Yes	O No	Liver Disease	O Yes	O No	Yellow Jaundice	O Yes	O No

Have you ever had any serious illness not listed above? O Yes O 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:** _____