NORTH SHORE DENTISTRY
2101 E. CALUMET ST.
APPLETON, WI 54915
(920) 731-1550

MEDICAL HISTORY

TODAY'S DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____
FIRST NAME/LAST NAME/MIDDLE INITIAL

YOUR PRIMARY CARE PHYSICIAN'S NAME: _____

HAVE YOU BEEN HOSPITALIZED OR HAD SURGERY IN THE LAST 7 YEARS? ☐ YES ☐ NO IF YES: _____

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? ☐ YES ☐ NO IF YES: _____

HAVE YOU TAKEN FOSAMAX, BONIVA, ACTONEL OR BISPHOSPHONATES FOR OSTEOPOROSIS? ☐ YES ☐ NO IF YES: _____

DO YOU USE ANY FORM OF TOBACCO? ☐ YES ☐ NO IF YES: _____

DO YOU REQUIRE PREMEDICATION (ANTIBIOTICS) BEFORE DENTAL APPTS? ☐ YES ☐ NO IF YES, WHY?: _____

DO YOU HAVE A FAMILY HISTORY OF HEAD, NECK, AND/OR ORAL CANCER? ☐ YES ☐ NO IF YES: _____

ARE YOU TAKING ANY MEDICATION, PILLS, DRUGS, OR VITAMINS? ☐ YES ☐ NO IF YES: _____

_____

_____

WOMEN, ARE YOU: ☐ PREGNANT/TRYING TO CONCEIVE ☐ NURSING ☐ TAKING ORAL CONTRACEPTIVES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

☐ ASPIRIN	☐ PENICILLIN	☐ CODEINE	☐ ACRYLIC
☐ METAL	☐ LATEX	☐ SULFA DRUGS	☐ LOCAL ANESTHETICS
☐ AMOXICILLIN	☐ TETRACYCLINE	☐ ERYTHOMYCIN	☐ IBUPROFEN

ANY OTHER ALLERGIES? ☐ YES ☐ NO IF YES: _____

DO YOU USE ANY CONTROLLED SUBSTANCES? ☐ YES ☐ NO IF YES: _____

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DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING (CHECK ANY THAT APPLY):

- ☐ AIDS/HIV POSITIVE
- ☐ ALZHEIMERS/ DEMENTIA
- ☐ ANAPHYLAXIS
- ☐ EMPHYSEMA
- ☐ EPILEPSY OR SEIZURES
- ☐ EXCESSIVE BLEEDING
- ☐ EXCESSIVE THIRST
- ☐ FAINTING SPELLS/DIZZINESS
- ☐ FREQUENT COUGH
- ☐ LEUKEMIA
- ☐ STROKE
- ☐ SWELLING OF LIMBS
- ☐ THYROID DISEASE
- ☐ HEART ATTACK/FAILURE
- ☐ HEART MURMUR
- ☐ HEART PACEMAKER
- ☐ ANXIETY/ DEPRESSION
- ☐ ULCERITIVE COLITIS
- ☐ CORTISONE MEDICATIONS
- ☐ DIABETES
- ☐ DRUG ADDICTION
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIVES OR RASH
- ☐ HYPOGLYCEMIA
- ☐ IRREGULAR HEARTBEAT
- ☐ KIDNEY PROBLEMS
- ☐ BREATHING PROBLEMS
- ☐ BRUISE EASILY
- ☐ CANCER
- ☐ CHEMOTHERAPY
- ☐ OSTEOPOROSIS
- ☐ PAIN IN JAW JOINTS
- ☐ PARATHYROID DISEASE
- ☐ STI/STD'S
- ☐ CLOTTING DISORDERS
- ☐ HEMOPHILIA
- ☐ HEPATITIS A
- ☐ HEPATITIS B OR C
- ☐ RHEUMATISM
- ☐ RHEUMATIC FEVER
- ☐ SCARLETT FEVER
- ☐ SHINGLES
- ☐ SICKLE CELL DISEASE
- ☐ SINUS TROUBLES
- ☐ BLOOD TRANSFUSION
- ☐ FREQUENT HEADACHES
- ☐ GENITAL HERPES
- ☐ GLAUCOMA
- ☐ MITRAL VALVE PROLAPSE
- ☐ TUBERCULOSIS
- ☐ TUMORS/ GROWTHS
- ☐ ULCERS
- ☐ YELLOW JAUNDICE
- ☐ RADIATION TREATMENTS
- ☐ RECENT WEIGHT LOSS
- ☐ RENAL DIALYSIS
- ☐ ANGINA
- ☐ ARTHRITIS/GOUT
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINT
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ FREQUENT DIARRHEA
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ LUNG DISEASE
- ☐ CHEST PAINS
- ☐ COLD SORES/ FEVER BLISTERS
- ☐ CONGENITAL HEART DISORDER
- ☐ HEART TROUBLE/ DISEASE
- ☐ CROHN'S DISEASE

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ YES ☐ NO

IF YES, PLEASE LIST THEM: _____

THESE QUESTIONS HAVE BEEN ANSWERED ACCURATELY, TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S HEALTH). IT'S MY RESPONSIBILITY TO INFORM THE PRACTICE OF ANY CHANGES IN MEDICAL STATUS.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE