Smiles on the Boulevard
609 Washington Blvd.
Belpre, OH 45714
740-423-8416

Medical History

Personal Information

Full name	
Nickname	
Home address	
Home phone	
Mobile or cellular phone	
Home email address	
Birthday (MM/DD/YYYY)	

General Information:

Are you under a physician's care now?	Y N	If yes,
Have you ever been hospitalized or had a major operation?	Y N	If yes,
Have you ever had a serious head or neck injury?	Y N	If yes,
Are you taking any medications, pills, or drugs?	Y N	If yes,
Do you take, or have you taken, Phen-Fen or Redux?	Y N	If yes,
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y N	If yes,
Are you on a special diet?	Y N	If yes,
Do you use tobacco?	Y N	If yes,
Do you use controlled substances?	Y N	If yes,

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Women:

Are you pregnant/trying to get pregnant?	Y N
Are you nursing?	Y N
Are you taking contraceptives?	Y N

Allergies:

Are you allergic to any of the following?

Aspirin	Y N	
Penicillin	Y N	
Codeine	Y N	
Acrylic	Y N	
Metal	Y N	
Latex	Y N	
Sulfa Drugs	Y N	
Local Anesthetics	Y N	
Other	Y N	If yes,

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

AIDS/HIV Positive	Y N	Hemophilia	Y N
Alzheimer's Disease	Y N	Hepatitis A	Y N
Anaphylaxis	Y N	Hepatitis B or C	Y N
Anemia	Y N	Herpes	Y N
Angina	Y N	High Blood Pressure	Y N
Arthritis/Gout	Y N	High Cholesterol	Y N
Artificial Heart Valve	Y N	Hives or Rash	Y N
Artificial Joint	Y N	Hypoglycemia	Y N
Asthma	Y N	Irregular Heartbeat	Y N
Blood Disease	Y N	Kidney Problems	Y N
Blood Transfusion	Y N	Leukemia	Y N
Breathing Problems	Y N	Liver Disease	Y N
Bruise Easily	Y N	Low Blood Pressure	Y N
Cancer	Y N	Lung Disease	Y N
Chemotherapy	Y N	Mitral Valve Prolapse	Y N
Chest Pains	Y N	Osteoporosis	Y N

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Cold Sores/Fever Blisters	Y N	Pain in Jaw Joints	Y N
Congenital Heart Disorder	Y N	Parathyroid Disease	Y N
Convulsions	Y N	Psychiatric Care	Y N
Cortisone Medicine	Y N	Radiation Treatments	Y N
Diabetes	Y N	Recent Weight Loss	Y N
Drug Addiction	Y N	Renal Dialysis	Y N
Easily Winded	Y N	Rheumatic Fever	Y N
Emphysema	Y N	Rheumatism	Y N
Epilepsy or Seizures	Y N	Scarlet Fever	Y N
Excessive Bleeding	Y N	Shingles	Y N
Excessive Thirst	Y N	Sickle Cell Disease	Y N
Fainting Spells/Dizziness	Y N	Sinus Trouble	Y N
Frequent Cough	Y N	Spina Bifida	Y N
Frequent Diarrhea	Y N	Stomach/Intestinal Disease	Y N
Frequent Headache	Y N	Stroke	Y N
Genital Herpes	Y N	Swelling of Limbs	Y N
Glaucoma	Y N	Thyroid Disease	Y N
Hay Fever	Y N	Tonsillitis	Y N
Heart Attack/Failure	Y N	Tuberculosis	Y N
Heart Murmur	Y N	Tumors or Growths	Y N
Heart Pacemaker	Y N	Ulcers	Y N
Heart Trouble/Disease	Y N	Venereal Disease	Y N
ADD/ADHD	Y N	Yellow Jaundice	Y N

Have you ever had any serious illness not listed above? Y N 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 (the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature or Patient, Parent or Guardian: _____ **Date:**