Daniel M. Sweeney, DDS

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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.

Patient Name ____________________ Birth Date ____________ Today's Date ____________

Question			
Are you under a physician's care now?	☐ Yes ☐ No	If yes:	Name: Phone:
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes:	
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes:	
Do you have anxiety, dental or otherwise?	☐ Yes ☐ No	If yes:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes:	
Do you have sleep apnea?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		
Do you use controlled substances?	☐ Yes ☐ 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 ☐ Local Anesthetics ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Ibuprofen ☐ Others? ____________

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

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

Have you ever had any serious illness not listed above? ☐ 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 charges in medical status.

X ______________________________ ____________

Signature of patient, Parent or Guardian Date