Jeffery Spilman D.D.S.

Medical History

Patient Name:____Birth Date:______________________

Although dental personnel primarily treat the area in an 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 physicians care now? ○ Yes ○ No explain:_____________________
Are you taking any medications? ○ Yes ○ No explain:_____________________
Have you ever taken Fosamax, Boniva, or Actonel? ○ Yes ○ No explain:_____________________
Do you use tobacco? ○ Yes ○ No explain:_____________________
Do you use controlled substances? ○ Yes ○ No explain:_____________________

Women: Are you
☐ Pregnant/trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?: Aspirin ☐ Acrylic ☐ Other:_________________
Penicillin ☐ Metal ☐ _________________
Codeine ☐ Sulfa Drugs ☐ _________________
Latex ☐ Local anesthetic ☐

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

☐ Aids/HIV Positive
☐ Alzheimer's Disease
☐ Anemia
☐ Angina
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Breathing Problem
☐ Cancer
☐ Cold Sores/Fever Blisters
☐ Convulsions
☐ Diabetes
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart trouble/Disease
☐ Hemophilia
☐ Hepatitis A, B or C
☐ Herpes
☐ High Blood Pressure
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Psychiatric Care
☐ Recent Weight Loss
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sinus Trouble
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Thyroid Disease
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Any serious illness not listed?
☐ Yes
☐ No
If yes, please explain_____________
____
____

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________________________________Date:______________