607-729-4539

Patient Medical History

Dr. Jerome T. Farrell II

PATIENT NAME _____ **DATE OF BIRTH** _____

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?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medication, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biophosphonates?	Yes	No	If yes, please explain: _____
Are you on a special diet?	Yes	No	If yes, please explain: _____
Do you use tobacco?	Yes	No	If yes, please explain: _____
Do you use controlled substances?	Yes	No	If yes, please explain: _____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal

Latex Sulfa Drugs Other: _____

If yes, please explain: _____

Women - Are you:

…pregnant/trying to get pregnant? _____ …nursing? _____ …taking oral contraceptives? _____

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

AIDS/HIV+	Y	N
Alzheimer's	Y	N
Anaphylaxis	Y	N
Anemia	Y	N
Angina	Y	N
Arthritis/Gout	Y	N
Artificial Heart Valve	Y	N
Artificial Joint	Y	N
Asthma	Y	N
Blood Disease	Y	N
Blood Transfusion	Y	N
Breathing Problem	Y	N
Bruise Easily	Y	N
Cancer	Y	N
Chemotherapy	Y	N
Chest Pains	Y	N
Cold Sores/Fever Blisters	Y	N
Congenital Heart Disorder	Y	N
Convulsions	Y	N
Cortisone Medicine	Y	N
Diabetes	Y	N
Drug Addiction	Y	N
Easily Winded	Y	N
Emphysema	Y	N
Epilepsy or Seizures	Y	N
Excessive Bleeding	Y	N
Excessive Thirst	Y	N
Fainting Spells/Dizziness	Y	N
Frequent Cough	Y	N
Frequent Diarrhea	Y	N
Frequent Headaches	Y	N
Genital Herpes	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Heart Attack/Failure	Y	N
Heart Murmur	Y	N
Heart Pacemaker	Y	N
Heart Trouble/Disease	Y	N
Hemophilia	Y	N
Hepatitis A	Y	N
Hepatits B or C	Y	N
Herpes	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Hives or Rash	Y	N
Hypoglycemia	Y	N
Irregular Heartbeat	Y	N
Kidney Problems	Y	N
Leukemia	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Lung Disease	Y	N
Mitral Valve Prolapse	Y	N
Osteoporosis	Y	N
Pain in Jaw Joints	Y	N
Parathyroid Disease	Y	N
Psychiatric Care	Y	N
Radiation Treatments	Y	N
Recent Weight Loss	Y	N
Renal Dialysis	Y	N
Rheumatic Fever	Y	N
Rheumatism	Y	N
Scarlet Fever	Y	N
Shingles	Y	N
Sickle Cell Disease	Y	N
Sinus Trouble	Y	N
Spina Bifida	Y	N
Stomach/Intestine Disease	Y	N
Stroke	Y	N
Swelling of Limbs	Y	N
Thyroid Disease	Y	N
Tonsilitis	Y	N
Tuberculosis	Y	N
Tumors or Growths	Y	N
Ulcers	Y	N
Venereal Disease	Y	N
Yellow Jaundice	Y	N
Other: _____		

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 office of any changes in medical status.

Signature: _____ Date: _____