Patient's Name: ______________________
Patient's Date of Birth: ______________________
Referring/General Dentist: ______________________

Dr. Gavin M. Aaron DDS, MS
Medical History Form

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.

CHECK THE BOX FOR YES, LEAVE UNCHECKED FOR NO

Question		
Are you under a physician's care now?	☐	If yes
Has a dentist or physician ever told you that you had a tumor or cancer?	☐	
Have you ever been hospitalized or had a major operation?	☐	If yes
Have you ever had a serious illness, head, or neck injury?	☐	If yes
Have you ever had excessive bleeding following extraction of a tooth or from a cut?	☐	
Are you taking any medications, pills, or drugs?	☐	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	
Have you ever been told not to take novocaine?	☐	
Do you use tobacco?	☐	If yes
Do you use controlled substances?	☐	If yes
Do you need to take antibiotics before for dental visits?	☐	If yes

Women: Please mark all that apply to you by checking the box. If none apply please skip this section.

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Please mark all that you are allergic to by checking the box. If none apply please skip this section.

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you have other allergies not listed above? ◯ Yes ◯ No If yes

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss	☐ Drug Addiction
☐ Hepatitis B or C	☐ Renal Dialysis	☐ Anemia	☐ Easily Winded
☐ Herpes	☐ Rheumatic Fever	☐ Angina	☐ Emphysema
☐ High Blood Pressure	☐ Arthritis	☐ Epilepsy or Seizures	☐ High Cholesterol
☐ Scarlet Fever	☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia
☐ Asthma	☐ Fainting Spells	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Kidney Problems	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Low Blood Pressure	☐ Cancer	☐ Glaucoma
☐ Lung Disease	☐ Thyroid Disease	☐ Chemotherapy	☐ Mitral Valve Prolapse
☐ Chest Pains	☐ Heart Attack/Failure	☐ Tuberculosis	☐ Cold Sores/Fever Blisters
☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths	☐ Congenital Heart Disorder
☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers	☐ Convulsions
☐ Heart Trouble/Disease	☐ Yellow Jaundice	☐ Dizziness	☐ Syphilis
☐ Have Prosthetic Joints			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X______________________________ Date:______________