Chestnut Dental Dental and Medical History(Copy)2024

Patient Name: Birth Date: Date Created:

Please list your Physician's name / Practice Name and Contact Phone Number below:

Have you been recently hospitalized? If yes, why? ◯ Yes ◯ No If yes

Are you taking any prescriptions, supplements, or OTC medications? (Please list below)

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

FOR WOMEN ONLY

Women: Are you...

Trying to get pregnant? ◯ Yes ◯ No	Nursing? ◯ Yes ◯ No	Taking oral contraceptives? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Foods	☐ Other: _____		

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

ADHD ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No
AIDS/HIV Positive ◯ Yes ◯ No	Drug/Alcohol Addiction ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No
Epilepsy or Seizures ◯ Yes ◯ No	Migraines / Headaches ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No	Angina ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Arthritis/Rheumatism ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No
Artifical Heart Valve ◯ Yes ◯ No	Anxiety ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Autism Spectrum Disorder ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Autoimmune Disorder ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No	Reflux/GERD ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No
Heart Trouble/Disease ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No
Heart Pacemaker ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No	Hepatitis ◯ Yes ◯ No
Sinus Trouble ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No
High Cholesterol ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No
Hives or Rash ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No
Hypoglycemia ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No
Tumors or Growths ◯ Yes ◯ No	Dental Fear ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No
Ulcers ◯ Yes ◯ No	Depression ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No
Tobacco Use ◯ Yes ◯ No	Lyme Disease ◯ Yes ◯ No	

Have you every had any serious illness not listed? ◯ 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:_____