Todd W. Garcia, DDS, PLLC

MEDICAL HISTORY

Patient Name: Birth Date:

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

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ 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
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Other			

Do you used controlled substances? ◯ Yes ◯ No If yes

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

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

Have you ever had any serious illness not listed?	◯ Yes ◯ No	If yes
Were you referred to our office?	◯ 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 changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____