Bayport Dental Care
594 Montauk Highway
Bayport, NY 11705
(631) 472-3333 www.BayportDental.com

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Although dental personnel primarily teat the area in and around your mouth, your mouth is 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 medications, prescription or over the counter? **____ Yes ____ No**

PLEASE LIST ALL MEDICATIONS: _____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **___ Yes ___ No**
Are you on any blood thinning medications including aspirin? **____ Yes ____ No**
Are you on a special diet? **____ Yes ____ No**
Do you use tobacco products? **____ Yes ____ No**
Do you use controlled substances? **____ Yes ____ No**

Are you allergic to any of the following? _____ Aspirin _____ Penicillin _____ Codeine
_____ Local Anesthetics _____ Acrylic _____ Metal
_____ Latex _____ Sulfa Drugs
_____ Other If yes, please explain: _____
_____

WOMEN ONLY:

Are you: Pregnant/Trying to get pregnant? **____ YES ____ NO**

Taking oral contraceptives? **____ YES ____ NO**

Nursing? **____ YES ____ NO**

Do you have, or have you had, any of the following? **(PLEASE ANSWER YES OR NO)**

AIDS/HIV Positive _____
Alzheimer's Disease _____
Anaphylaxis _____
Anemia _____
Angina _____
Arthritis/Gout _____
Artificial Heart Valve _____
Artificial Joints _____
Asthma _____
Blood Disease _____
Blood Transfusion _____
Breathing Problems _____
Bruise Easily _____
Cancer _____
Chemotherapy _____
Chest Pains _____
Cold Sores/Fever Blisters _____
Congenital Heart Disorder _____
Convulsions _____
Cortisone Medicine _____
Diabetes _____
Drug Addiction _____
Easily Winded _____
Emphysema _____
Epilepsy/Seizures _____
Excessive Thirst _____
Fainting Spells/Dizziness _____
Frequent Cough _____
Frequent Diarrhea _____
Frequent Headaches _____
Genital Herpes _____
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 Treatment _____
Recent Weight Loss _____
Rheumatic Fever _____
Rheumatism _____
Scarlet Fever _____
Shingles _____
Sickle Cell Disease _____
Sinus Troubles _____
Spina Bifida _____
Stomach/Intestinal Disease _____
Stroke _____
Swelling of Limbs _____
Thyroid Disease _____
Tuberculosis _____
Tumors or Growths _____
Ulcers _____
Venereal Disease _____
Yellow Jaundice _____