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

To the best of my knowledge the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform Bayport Dental Care of any changes in my medical status.

PATIENT SIGNATURE: _____ **DATE:** _____