Amanda B. Boltwood, D.D.S.,P.L.L.C.

Date 6/6/2017

BOLTWOOD MEDICAL HISTORY 2

Patient Name: Birth Date: Date Created:

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 answering the following questions.

Are you under a physician's care for any particular purpose?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation within the last 5 years	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury within the last 5 years	◯ Yes ◯ No	If yes	
Ever taken Fosamax, Boniva, Actonel or any other drugs containing bisphosphonates (drugs to prevent bone loss)?	◯ Yes ◯ No	If yes	
Have you had any substance abuse?	◯ Yes ◯ No	If yes	
Do you use tobacco?	◯ Yes ◯ No		

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Metal
☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	☐ Iodine
☐ Peanuts			

Any Other Allergies that are not listed: ◯ Yes ◯ No If yes

WOMEN ARE YOU:

Nursing	◯ Yes ◯ No	Taking contraceptives?	◯ Yes ◯ No	Pregnant	◯ Yes ◯ No
trying to get pregnant	◯ Yes ◯ No				

If Pregnant how far along?

Check If you have or have had any of the following:

Acid Reflux	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	LowBlood Pressure	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fainting	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No
Artificial Heart Valves	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No
Artificail Joints	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Resppiratory Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	HeartMurmur	◯ Yes ◯ No	Sinus	◯ Yes ◯ No
Back Problems	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No	Skin Rash	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Swelling of Feet or Ankles	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Jaw Pain	◯ Yes ◯ No	Ulcer	◯ Yes ◯ No
Choleserol (high)	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Veneral Disease	◯ Yes ◯ No
Cortisone Treatments	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No		

Any other serious illness not listed above? ◯ Yes ◯ No If yes

LIST OF CURRENT MEDICATION

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:_____