Time 11:30 AM

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

Date 5/25/2016

BOLTWOOD MEDICAL HISTORY 1(Copy)

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

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

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

Have you had any substance abuse? ◯ Yes ◯ No If yes

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

WOMEN

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other Allergies: ◯ Yes ◯ No If yes

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

Condition	Yes / No	Condition	Yes / No	Condition	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	Glaucoma	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No
Artificial Joints	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Respiratory Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Skin Rash	◯ Yes ◯ No
Back Problems	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Swelling of Feet or Ankles	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Ulcer	◯ Yes ◯ No
Cortisone Treatments	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Veneral Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No		

Have you ever had any serious illness not listed ◯ 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:__________