Terrance Ware, DDS
5800 Ridgewood Rd
Suite 104
Jackson, MS 39211
769.251.5909

Today's Date: _____ **MEDICAL HISTORY**

Last Name: _____ First Name: _____ Date of Birth:_____

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 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, pills, or drugs? ____Yes ____No If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? ____Yes ____No If yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ____Yes ____No If yes, please explain:_____
Are you on a special diet? ____Yes ____No If yes, please explain:_____
Do you use tobacco? ____Yes ____No If yes, what kind and how much:_____
Do you use controlled substances? ____Yes ____No

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
____Local Anesthetics ____Sulfa Drugs ____Other: _____

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

AIDS/HIV Positive ___Yes ___No
Convulsions, Epilepsy, Seizures ___Yes ___No
Low Blood Pressure ___Yes ___No
Anaphylaxis ___Yes ___No
Anemia ___Yes ___No
Angina ___Yes ___No
Arthritis/Gout ___Yes ___No
Artificial Joints ___Yes ___No
If Yes, What/When: _____
Asthma ___Yes ___No
Issues with Blood/Bleeding:
Blood Disease ___Yes ___No
Blood Transfusion ___Yes ___No
Excessive Bleeding ___Yes ___No
Hemophilia ___Yes ___No
Bruise Easily ___Yes ___No

Breathing Problems ___Yes ___No
Emphysema ___Yes ___No

Liver Disease ___Yes ___No
Leukemia ___Yes ___No
Kidney Problems ___Yes ___No
Hypoglycemia ___Yes ___No
Lung Disease ___Yes ___No
Cortisone Medicine ___Yes ___No
Diabetes ___Yes ___No
Drug Addiction ___Yes ___No
Fainting Spells/Dizziness ___Yes ___No
Heart Problems:
Congenital Heart Disorder ___Yes ___No
Heart Attack/Failure ___Yes ___No
Heart Murmur ___Yes ___No
Heart Pacemaker ___Yes ___No
Heart Trouble/Disease ___Yes ___No
Artificial Heart Valve ___Yes ___No
Mitral Valve Prolapse ___Yes ___No

Hepatitis A ___Yes ___No
Cancer ___Yes ___No
If Yes, What/When: _____

Osteoporosis ___Yes ___No
Parathyroid Disease ___Yes ___No
Psychiatric Care ___Yes ___No
Renal Dialysis ___Yes ___No
Rheumatism ___Yes ___No
Sickle Cell disease ___Yes ___No
Spina Bifida ___Yes ___No
Stomach Disease ___Yes ___No
Stroke ___Yes ___No
Swelling of Limbs ___Yes ___No
Thyroid Disease ___Yes ___No
Tuberculosis ___Yes ___No
Tumors or Growths ___Yes ___No
Ulcers ___Yes ___No
High Cholesterol ___Yes ___No
High Blood Pressure ___Yes ___No
Herpes ___Yes ___No

Hepatitis B or C ___Yes ___No

Have you ever had any serious illness not listed: ___Yes ___No If Yes, please explain_____
_____
_____

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 or Patient, Parent or Guardian:

X ____ Date:________________________