Dental Designs by Holst & Associates
401 East Robinson
Knoxville, IA 50138
(641) 828-8778

DENTAL DESIGNS
BY HOLST & ASSOCIATES

MEDICAL HISTORY

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.

1. ❒Yes ❒No Are you under a physician care now? Why?_____Date of last physical examination?_____
2. ❒Yes ❒No Have you ever been hospitalized or had a major operation? Please list:_____
3. ❒Yes ❒No Have you ever had a serious head or neck injury? Please list:_____
4. ❒Yes ❒No Are you taking any medications, pills, vitamins, herbs or drugs? Please list:_____
5. ❒Yes ❒No Do you take or have you ever taken Phen-Fen or Redux? When?_____
6. ❒Yes ❒No Have you ever taken Fosamax, Boniva, Actonal or any other medications containing bisphosphonates?
7. ❒Yes ❒No Are you on a special diet? Describe:_____
8. ❒Yes ❒No Do you use tobacco? Please list:_____
9. ❒Yes ❒No Do you use controlled substances? Please list: _____
10. ❒Yes ❒No WOMEN: Are you now or trying to get pregnant? ❒ Nursing? ❒ Taking oral contraceptives?
11. Who is your preferred Pharmacy?_____ Phone Number_____
12. Are you allergic to any of the following:
    ❒Aspirin ❒Penicillin ❒Codeine ❒Acrylic ❒Metal ❒Latex ❒Local Anesthetics ❒Sulfa Drugs ❒Other
    Type of reaction:_____
13. Do you have or have you had any of the following:

❒AIDS/HIV Positive
❒Alzheimer's Disease
❒Anaphylaxis
❒Anemia
❒Angina
❒Arthritis/Gout
❒Artificial Heart Valve*
❒Artificial Joint*
❒Asthma
❒Blood Disease
❒Blood Transfusion
❒Breathing Problem
❒Bruise Easily
❒Cancer
❒Chemotherapy
❒Chest Pains
❒Cold Sores/Fever Blisters
❒Congenital Heart Disorder
❒Convulsions
❒Cortisone Medicine
❒Diabetes
❒Drug Addiction
❒Easily Winded
❒Eating Disorder
❒Emphysema
❒Epilepsy or Seizures
❒Excessive Bleeding
❒Excessive Thirst
❒Fainting Spells/Dizziness
❒Frequent Cough
❒Frequent Diarrhea
❒Frequent Headaches
❒Gastric Reflux | GERD
❒Genital Herpes
❒Glaucoma
❒Hay Fever
❒Heart Attack/Failure
❒Heart Defibrillator*
❒Heart Murmur*
❒Heart Pacemaker*
❒Heart Troubles/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 Treatments
❒Recent Weight Loss
❒Renal Dialysis
❒Rheumatic Fever*
❒Rheumatism
❒Scarlet Fever
❒Shingles
❒Sickle Cell Disease
❒Sinus Trouble
❒Snore | Sleep Apnea
❒Spina Bifida
❒Stomach/Intestinal Disease
❒Stroke
❒Swelling of Limbs
❒Thyroid Disease
❒Tonsilitis
❒Tuberculosis
❒Tumors or Growths
❒Ulcers
❒Venereal Disease
❒Yellow Jaundice

*Condition may require medication

14. ❒Yes ❒No Have you ever had any serious illness not listed above? Please list:_____
15. Do you have any comments? _____

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.

Patient Name (Please print)_____ Date _____

Patient or Guardian Signature_____ Date _____

Reviewing Dentist Signature _____ Date _____