Dr. Francis C. Candre
Medical History

Patient Name: _____ **Birth Date**: _____

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.

Have you traveled abroad in the last month? **Y N**

If you are under a physician's care now? **Y N** If yes, why? _____

Have you ever been hospitalized or had a major operation? **Y N** If yes, why?_____

Have you ever had a serious head or neck injury? **Y N** If yes, what? _____

Are you taking any medications, pills, or drugs? **Y N** If yes, what?_____

Do you take, or have you taken, Phen-Fen or Redux? **Y N** If yes, why?_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **Y N**

Are you on a special diet? **Y N**

Do you vape or use tobacco? **Y N** If yes, what?_____

Do you use controlled substances? **Y N** If yes, what?_____

Women: Are you… __Pregnant/Trying to get pregnant? __Nursing? __Taking oral contraceptives?

Are you allergic to the following? __Aspirin __Penicillin __Codeine __Acrylic __Metal __Latex

__Sulfa Drugs __Local Anesthetics Other If yes_____

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

AIDS/HIV Positive	**Y N**	**Alzheimer's disease**	**Y N**	**Anaphylaxis**	**Y N**
Anemia	**Y N**	**Angina**	**Y N**	**Arthritis/Gout**	**Y N**
Artificial Heart Valve	**Y N**	**Artificial Joint**	**Y N**	**Asthma**	**Y N**
Blood Disease	**Y N**	**Blood Transfusion**	**Y N**	**Breathing Problems**	**Y N**
Bruise Easily	**Y N**	**Cancer**	**Y N**	**Chemotherapy**	**Y N**
Chest Pains	**Y N**	**Cold Sores/Fever Blisters**	**Y N**	**Congenital Heart Disorder**	**Y N**
Convulsions	**Y N**	**Cortisone Medicine**	**Y N**	**Diabetes**	**Y N**

Drug Addiction	**Y N**	**Easily Winded**	**Y N**	**Emphysema**	**Y N**
Epilepsy or Seizure	**Y N**	**Excessive Bleeding**	**Y N**	**Excessive Thirst**	**Y N**
Fainting/Dizziness	**Y N**	**Frequent Cough**	**Y N**	**Frequent Diarrhea**	**Y N**
Frequent Headaches	**Y N**	**Genital Herpes**	**Y N**	**Glaucoma**	**Y N**
Hay Fever	**Y N**	**Heart Attack/Failure**	**Y N**	**Heart Murmur**	**Y N**
Heart Pacemaker	**Y N**	**Heart Trouble/Disease**	**Y N**	**Hemophilia**	**Y N**
Hepatitis A	**Y N**	**Hepatitis B or C**	**Y N**	**High Blood Pressure**	**Y N**
High Cholesterol	**Y N**	**Hives or Rash**	**Y N**	**Hypoglycemia**	**Y N**
Irregular Heartbeat	**Y N**	**Kidney Problems**	**Y N**	**Leukemia**	**Y N**
Liver Disease	**Y N**	**Low Blood Pressure**	**Y N**	**Lung Disease**	**Y N**
Mitral Valve Prolapse	**Y N**	**Oral Herpes**	**Y N**	**Osteoporosis**	**Y N**
Pain in Jaw Joints	**Y N**	**Parathyroid Disease**	**Y N**	**Psychiatric Care**	**Y N**
Radiation Treatments	**Y N**	**Recent Weight Loss**	**Y N**	**Renal Dialysis**	**Y N**
Rheumatic Fever	**Y N**	**Rheumatism**	**Y N**	**Scarlet Fever**	**Y N**
Shingles	**Y N**	**Sickle Cell**	**Y N**	**Sinus Trouble**	**Y N**
Spina Bifida	**Y N**	**Stomach/Intestinal Disease**	**Y N**	**Stroke**	**Y N**
Swelling of Limbs	**Y N**	**Thyroid Disease**	**Y N**	**Tonsillitis**	**Y N**
Tuberculosis	**Y N**	**Tumors or Growths**	**Y N**	**Ulcers**	**Y N**
Venereal Disease	**Y N**	**Yellow Jaundice**	**Y N**	**Malignant Hyperthermia**	**Y N**

Have you ever had any serious illness not listed above? **Y N** If yes, what?_____

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.

Signature of Patient, Parent or Guardian:

X_____ Date: _____