CONFIDENTIAL

LIBERTY DENTAL ASSOCIATES
PATIENT MEDICAL HISTORY/QUESTIONNAIRE

Liberty Dental Associates
Dr. Glenn E. Casteel
12055 Sheraton Lane; Building #5
Cincinnati, Ohio 45246
Phone: (513) 541-1941
Fax: (513) 541-0773

Health Summary:
(Office Use Only)

PLEASE COMPLETE THE FOLOWING FORM (3 PAGES):

Patient's Name: _____ **Date:** _____

YES NO

1. **Please list your Medical Doctor's name, address, and phone number:** _____
_____
_____

2. **Have you been to see this Medical Doctor or another one within the past 2 years?** ☐ ☐
If yes, for what?: _____

3. **Have you been a patient in the hospital with the past 2 years?** _____ **If yes, for what?:** _____ ☐ ☐
_____

4. **Please check (☑)any condition below which you have had in the past, or now have:**

GENERAL
☐-Tire Easily/Weakness
☐-Marked Weight Change
☐-Night Sweats
☐-Persistent Fever
☐-Poor General Health

SKIN & MOUTH TISSUES (GUMS)
☐-Rash, Hives, Eruptions
☐-Change in Skin Color
☐-Change in Mole (Color, Shape, Size)
☐-Cold Sores, Fever Blisters
☐-Sores in Mouth
☐-Herpes
☐-Bleeding Gums

EYES
☐-Visual Changes
☐-Glaucoma

NOSE
☐-Frequent Nosebleeds
☐-Sinus Problems
☐-Seasonal Allergies

EARS
☐-Loss of Hearing
☐-Reduction in Hearing
☐-Wear Hearing Aids
☐-Ringing in Ears

BONES AND MUSCLES
☐-Osteoporosis
☐-Arthritis/Rheumatism
☐-Artificial Joints/Limbs/Hips
☐-Plates, Pins, or Screws Placed
☐-Cortisone Therapy/Treatment
☐-Enlarged "Gland" or Lymph Nodes

THROAT
☐-Soreness
☐-Hoarseness
☐-Growths

NERVOUS SYSTEM
☐-Stroke
☐-Headaches
☐-Convulsions/Seizures
☐-Epilepsy
☐-Numbness/Tingling
☐-Dizziness
☐-Fainting
☐-Anorexia
☐-Bulimia
☐-Psychological Treatment
☐-Psychiatric Treatment
☐-General Nervousness

RESPIRATORY
☐-Tuberculosis
☐-Emphysema
☐-Lung Disease
☐-Hay Fever
☐-Asthma
☐-Persistent Cough
☐-Excessive Sputum (phlegm)
☐-Bloody Sputum (phlegm)
☐-Difficulty Breathing While Lying Down
☐-Bronchitis

DIGESTIVE SYSTEM
☐-Jaundice
☐-Liver Disease
☐-Alcohol Treatment
☐-Ulcers
☐-Change in Appetite
☐-Black, Bloody, or Pale Stools

ENDOCRINE
☐-Diabetes
☐-Family History of Diabetes
☐-Thyroid Condition or Goiter

HEART AND BLOOD VESSELS
☐-Rheumatic Fever
☐-Heart Murmur
☐-Chest Pains/Discomfort
☐-Mitral Valve Prolapse
☐-Hypertension
☐-Hemophilia
☐-Other Blood Dyscrasia
☐-Hepatitis; Type: _____
☐-Yellow Jaundice
☐-Blood Transfusions
☐-Congenital Heart Lesions
☐-Artificial Heart Valve
☐-Heart Pacemaker
☐-Angina Pectoris (Chest Pain)
☐-Heart Failure/Attack
☐-Heart Problems
☐-Heart Disease
☐-Heart Surgery
☐-Angiogram
☐-Angioplasty/Stent Placement
☐-High Blood Pressure
☐-Low Blood Pressure
☐-Shortness of Breath

URINARY
☐-Kidney Disease
☐-Increase in Frequency of Urination
☐-Burning on Urination
☐-Urethral Discharge
☐-Blood in Urine
☐-Venereal Disease
☐-Kidney Stones

BLOOD
☐-Bruise Easily
☐-Anemia
☐-Blood Transfusion
☐-Bleeding Tendency
☐-Circulatory Problems

OTHER
☐-Latex Sensitivity/Allergy
☐-X-Ray or Radiation Therapy
☐-Chemotherapy
☐-Tumors or Growths
☐-Cancer
☐-Leukemia
☐-A.I.D.S.
☐-A.R.C. (AIDS Related Complex)
☐-H.I.V. +
☐-Sickle Cell Anemia
☐-Respiratory Disease (Not listed)
☐-Malnutrition
☐-Drug Addiction
☐-Alcohol Intolerance
☐-Alcohol Addiction
☐-Back Surgery
☐-Chronic Backache
☐-Occasional Backache
☐-Vertigo
☐-Parental/Guardian Abuse
☐-Spousal Abuse
☐-Dementia
☐-Alzheimer's
☐-Xerostomia (Dry Mouth)
☐-Excessive Saliva
☐-Other (Please Describe):

PLEASE COMPLETE PAGES 2 & 3 (THIS IS PAGE 1 OF 3)

CONFIDENTIAL

Continued From Page 1

YES NO

5. Have you had any operations or surgeries? If yes, please describe:_____ ☐ ☐

_____

Any complications, please list: _____

6. Have you ever experienced any excessive bleeding requiring special treatment? If so, please describe: ☐ ☐

_____

7. Are you currently taking any medicines, drugs, or pills of any kind (including non-prescription or herbal): ☐ ☐
If yes, please list name and dosage: _____

_____

_____

8. Do you have any allergies or adverse reactions to drugs or medicine? If yes, please describe _____ ☐ ☐

_____

9. Are you allergic to any dental anesthetics (Novocaine, Lidocaine, Nitrous Oxide, etc.)? If yes, what: _____ ☐ ☐

_____

10. When you walk up stairs, or take a walk, do you ever have to stop because of pain in the chest, shortness of breath, or because you tire easily? ☐ ☐

11. Do your ankles swell during the day? ☐ ☐

12. Do you sleep on more than two pillows? ☐ ☐

13. Do you wake from sleep, short of breath? ☐ ☐

14. Have you <u>Unintentionally</u> lost or gained more than 10 pounds in the past year? ☐ ☐

15. Are you on a special diet? If yes, please describe: _____ ☐ ☐

16. Has a medical professional ever advised you that you have a cancer or tumor? If yes, please describe: ☐ ☐

_____

17. Does your occupation bring you into contact with blood, blood products, or needles? If yes, please describe: _____ ☐ ☐

18. Describe your overall health in your words: _____

_____

19. Do you take any type of sleeping pills, sedatives/tranquilizers, or barbiturates? If yes, please list: _____ ☐ ☐

_____

20. If you have high blood pressure, is it well controlled with medicines? If no, please explain: _____ ☐ ☐

_____

21. Are you taking any blood thinners (including aspirin)? If yes, please list: _____

_____

22. Is there any condition, disease, or problem, not listed yet, that you think we need to know about? If yes, please list: _____ ☐ ☐

CONFIDENTIAL

FOR FEMALE PATIENTS ONLY

Continued From Page 2

YES NO

1. Are you pregnant? If yes, please list due date:_____ ☐ ☐

   Any complications, please list: _____

2. Are you practicing birth control?
   If you are using birth control pills, please list type and dosage: _____ ☐ ☐

   _____

3. Do you anticipate becoming pregnant soon? ☐ ☐

4. Do you suffer with PMS (Pre-Menstrual Syndrome), or problems associated with your menstrual period? ☐ ☐

   If yes, please explain: _____

5. Are you taking any type of hormone therapy (other than birth control)? ☐ ☐

   If yes, please describe: _____

All Patients Please Read This Next Section—Then Sign And Date

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED ALL QUESTIONS, AND ADDRESSED ALL STATEMENTS ON ALL THREE PAGES OF THIS MEDICAL HISTORY/QUESTIONNAIRE FORM, HONESTLY AND CORRECTLY. IF THERE IS ANY CHANGE IN MY HEALTH, MEDICINES, ETC. I WILL INFORM THIS DENTAL OFFICE AT MY NEXT APPOINTMENT OR BEFORE. THIS INFORMATION IS FOR MEDICAL USE ONLY (per HIPAA Regulations). I ALSO AGREE TO ALLOW THIS CONFIDENTIAL INFORMATION TO BE SHARED WITH PHYSICIANS, HEALTH PROFESSIONALS, REFERRING DENTISTS, CLINICAL AND DENTAL LABORATORIES, PHARMACIES, OR ANY OTHER HEALTHCARE PERSONNEL PROVIDING ME TREATMENT:

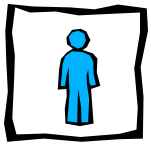
DATE: _____ SIGNATURE OF PATIENT: _____
(or Parent/Guardian if under age 18)

FOR OFFICE USE ONLY

REVIEWED WITH THE PATIENT ON ___/___/___ SIGNATURE:_____

CONFIDENTIAL

FOR MALE PATIENTS ONLY



Continued From Page 2

Please advise this office of any changes in your medical health.

All Patients Please Read This Next Section—Then Sign And Date

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED ALL QUESTIONS, AND ADDRESSED ALL STATEMENTS ON ALL THREE PAGES OF THIS MEDICAL HISTORY/QUESTIONNAIRE FORM, HONESTLY AND CORRECTLY. IF THERE IS ANY CHANGE IN MY HEALTH, MEDICINES, ETC. I WILL INFORM THIS DENTAL OFFICE AT MY NEXT APPOINTMENT OR BEFORE. THIS INFORMATION IS FOR MEDICAL USE ONLY (per HIPAA Regulations). I ALSO AGREE TO ALLOW THIS CONFIDENTIAL INFORMATION TO BE SHARED WITH PHYSICIANS, HEALTH PROFESSIONALS, REFERRING DENTISTS, CLINICAL AND DENTAL LABORATORIES, PHARMACIES, OR ANY OTHER HEALTHCARE PERSONNEL PROVIDING ME TREATMENT:

DATE: _____ **SIGNATURE OF PATIENT:** _____
(or Parent/Guardian if under age 18)

FOR OFFICE USE ONLY

REVIEWED WITH THE PATIENT ON ___/___/___ **SIGNATURE:**_____