COOL SPRINGS FAMILY DENTISTRY, PLLC

@Moores Lane

Patient Medical History

		Yes	No
1.	Are you under medical treatement now?	◯	◯
2.	Have you been hospitalized for any surgical operation or serious illness within the last five years?	◯	◯
	If yes, please explain ______________________________		
	____		
	____		
3.	Are you taking any medications including non-prescriptic drugs? Please list :______________________________	◯	◯
	____		
	____		
	____		
	____		
	____		
4.	Have you ever taken Fen-Phen/Redux?	◯	◯
5.	Have you ever taken Fosamax, Boniva, Actonel or any	◯	◯
	cancer medications containing bisphosphonates?	◯	◯
6.	Have you taken Viagra, Revoti, Cialis, or Levitra within the last 24 hours?	◯	◯
7.	Do you use tobacco?	◯	◯
	tobacco type/frequency:____________________________		
8.	Do you use a controlled substance?	◯	◯
9.	Are you wearing contact lenses?	◯	◯
10.	Are you allergic or have any reactions to the following:		
	Local Anesthetics (ie: Novocaine)	◯	◯
	Penicillin or other antibiotics	◯	◯
	Sulfa drugs	◯	◯
	Barbiturates	◯	◯
	Sedatives	◯	◯
	Iodine	◯	◯
	Aspirin	◯	◯
	Any Metals (Nickel, Mercury, etc.)	◯	◯
	Latex Rubber	◯	◯
	Other (please list)_____________________________	◯	◯
11.	Do you have a persistent cough or throat clearing not associated with known illness(lasting more than 5 weeks	◯	◯
12.	Are you pregnant or think you may be?	◯	◯
	Are you nursing?	◯	◯
	Are you taking contraceptives?	◯	◯

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

	Yes	No	Date
Heart trouble/Disease	◯	◯	________
Heart Attack/Failure	◯	◯	________
Artificial Heart Valve	◯	◯	________
Cardiac Pacemaker	◯	◯	________
Heart Murmer	◯	◯	________
Angina	◯	◯	________
High Blood Pressure	◯	◯	________
Low Blood Pressure	◯	◯	________
Rheumatic Fever	◯	◯	________
Stroke	◯	◯	________
Swollen Ankles	◯	◯	________
Fainting/Seizures/Epilepsy/Convulsions	◯	◯	________
Asthma	◯	◯	________
Emphysema	◯	◯	________
Allergies/Hay Fever	◯	◯	________
Tuberculosis	◯	◯	________
Anemia or Hemophilia	◯	◯	________
Leukemia	◯	◯	________
Aids or HIV infection	◯	◯	________
Cancer: ____________________________	◯	◯	________
Chemotherapy/Radiation	◯	◯	________
Kidney Disease	◯	◯	________
Diabetes Type I	◯	◯	________
Diabetes Type II	◯	◯	________
Stomach troubles/Ulcers	◯	◯	________
Anorexia/Bulimia	◯	◯	________
Acid Reflux	◯	◯	________
Liver Disease	◯	◯	________
Hepatitis: __________________________	◯	◯	________
Arthritis	◯	◯	________
Osteoporosis	◯	◯	________
Joint Replacement of: ________________	◯	◯	________
Thyroid Problem/Disease	◯	◯	________
Herpes/Fever Blisters/Cold Sores	◯	◯	________
STD: ______________________________	◯	◯	________
Alzheimers Disease/Dementia	◯	◯	________
Psychiatric Care	◯	◯	________
Drug Addiction	◯	◯	________
Have you ever had any serious illness not listed?	◯	◯	________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health and my provider. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to a third party health practitioner.

Patient Name ____

Signature ____ Date ______________