06/09/2022

Medical History Form

Patient Name:

Date of Birth:

Sex:

Emergency Contact ______________________

Emergency Contact Phone ______________________

Emergency Contact Relationship ______________________

Do you have any of the following diseases or problems

Active Tuberculosis .... Yes No

Persistent cough greater than a 3 week duration .... Yes No

Cough that produces blood .... Yes No

Been exposed to anyone with tuberculosis .... Yes No

Medical History

Are you now under the care of a physician? .... Yes No

Physician Name ______________________

Phone (including area code) ______________________

Address/City/State/Zip ______________________

Are you in good health? .... Yes No

Has there been any change in your general health within the past year? .... Yes No

If yes, what condition is being treated? ______________________

Date of last physical exam ______________________

Have you had a serious illness, operation or been hospitalized in the past 5 years? .... Yes No

If yes, what was the illness or problem? ______________________

Are you taking or have you recently taken any prescription or over the counter medicine(s)? .... Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

____

Do you wear contact lenses? .... Yes No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? .... Yes No

Date ______________________

If yes, have you had any complications? ______________________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began ______

Do you use controlled substances (drugs)? .... Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? .... Yes No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED ______

Do you drink alcoholic beverages? .... Yes No

If yes, how much alcohol did you drink in the last 24 hours? ______

If yes, how much do you typically drink in a week? ______

WOMEN ONLY. Are you:

Pregnant .... Yes No

Number of weeks ______

Taking birth control pills or hormonal replacement? .... Yes No

Nursing? .... Yes No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics	Yes	No	Latex (rubber)	Yes	No
Aspirin	Yes	No	Iodine	Yes	No
Penicillin or other antibiotics	Yes	No	Hay fever/seasonal	Yes	No
Barbiturates, sedatives, or sleeping pills	Yes	No	Animals	Yes	No
Sulfa drugs	Yes	No	Food	Yes	No
Codeine or other narcotics	Yes	No	Other	Yes	No
Metals	Yes	No	If Other, please specify: ______		

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve	Yes	No	Congenital heart disease (CHD)	Yes	No
Previous infective endocarditis	Yes	No	Unrepaired, cyanotic CHD	Yes	No
Damaged valves in transplanted heart	Yes	No	Repaired (completely) in the last 6 months	Yes	No
			Repaired CHD with residual defects	Yes	No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease	Yes	No	Heart attack	Yes	No
Angina	Yes	No	Heart murmur	Yes	No
Arteriosclerosis	Yes	No	Low blood pressure	Yes	No
Congestive heart failure	Yes	No	High blood pressure	Yes	No
Damaged heart valves	Yes	No	Other congenital heart defects	Yes	No

Mitral valve prolapse .... Yes No
Pacemaker .... Yes No
Rheumatic fever .... Yes No
Rheumatic heart disease .... Yes No
Abnormal bleeding .... Yes No
Anemia .... Yes No
Blood transfusion .... Yes No
If yes, date ____________
Hemophilia .... Yes No
AIDS or HIV .... Yes No
Arthritis .... Yes No
Autoimmune disease .... Yes No
Rheumatoid arthritis .... Yes No
Systemic lupus erythematosus .... Yes No
Asthma .... Yes No
Bronchitis .... Yes No
Emphysema .... Yes No
Sinus trouble .... Yes No
Tuberculosis .... Yes No
Cancer/Chemotherapy/Radiation Treatment Yes No
Chest pain upon exertion .... Yes No
Chronic pain .... Yes No
Diabetes Type I or II .... Yes No
Eating disorder .... Yes No

Malnutrition .... Yes No
Gastrointestinal disease .... Yes No
G.E. Reflux/persistent heartburn .... Yes No
Thyroid problems .... Yes No
Stroke .... Yes No
Glaucoma .... Yes No
Hepatitis, jaundice or liver disease .... Yes No
Epilepsy .... Yes No
Fainting spells or seizures .... Yes No
Neurological disorders .... Yes No
If yes, please specify ____________
Sleep disorder .... Yes No
Mental health disorders .... Yes No
Specify ____________
Recurrent infections .... Yes No
Type of infection ____________
Kidney problems .... Yes No
Night sweats .... Yes No
Osteoporosis .... Yes No
Persistent swollen glands in neck .... Yes No
Severe headaches/migraines .... Yes No
Severe or rapid weight loss .... Yes No
Sexually transmitted disease .... Yes No
Excessive urination .... Yes No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .... Yes No

Name of physician or dentist making recommendation (include phone number) ____________

Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No

Please explain ____________

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Signature of Patient/Legal Guardian