MEDICAL HISTORY

NAME_____

DATE _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING EITHER YES OR NO AND FILLING IN ALL BLANK SPACES THAT ARE INDICATED. ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND ARE CONFIDENTIAL. CORRECT AND COMPLETE ANSWERS ARE IMPORTANT AND MAY SIGNIFICANTLY IMPACT YOUR TREATMENT.

- **The name and address and phone # of my personal physician is** _____
  _____
  _____
- **The date of my last visit to a physician**_____
- **Are you now under the care of a physician?** ..... Yes No
  Physician's name _____
  If so, what is the condition being treated? _____
- **Have you ever had any serious illness?** ..... Yes No
  What was the problem?_____
- **Have you had previous surgery?** ..... Yes No
  Please list all previous surgeries:
  Surgical Procedure **Date of Surgery**
  _____
  _____
  _____
  _____
- **Please indicate if you have or have had any of the following**

Rheumatic fever	Yes	No	Rheumatic heart disease	Yes	No
Heart trouble	Yes	No	Heart murmur	Yes	No
Angina (chest pain)	Yes	No	Heart attack (myocardial infarction)	Yes	No
Atrial Fibrillation	Yes	No	Date(s)_____		
Heart abnormality since birth	Yes	No	High blood pressure	Yes	No
Pain in your chest on exertion	Yes	No	Shortness of breath		
Swelling of your ankles	Yes	No	after mild exercise	Yes	No
Coronary Artery Stents	Yes	No	Coronary Artery bypass grafts	Yes	No
Heart Valve replacement	Yes	No	Defibrillator	Yes	No
Stroke	Yes	No	Heart palpitations	Yes	No
Asthma	Yes	No	Bronchitis	Yes	No
Hay fever	Yes	No	Fainting spells or seizures	Yes	No
Hives or skin rash	Yes	No	Kidney trouble	Yes	No
Tuberculosis	Yes	No	Persistent cough, cough up blood	Yes	No
Sexually transmitted disease	Yes	No	Previous HIV test	Yes	No
Stomach or intestinal ulcers	Yes	No	Hepatitis	Yes	No
____Active ____Non-active			____Type A ____Type B ____Type C		
Diabetes	Yes	No	Arthritis or Joint problems	Yes	No
____Insulin dependent			Hip replacement L or R	Yes	No
____Non-insulin dependent			Knee replacement L or R	Yes	No

- **Have you had abnormal bleeding associated with extractions, surgery, or trauma** ..... Yes No
- **Ever had surgery or radiation treatments for tumor, cancer, or other conditions** ..... Yes No
- **Do you wear contact lenses?** ..... Yes No
- **Have you ever had general anesthesia? (been put to sleep)** ..... Yes No
  If so, did you have any problems with anesthesia ..... Yes No
  Please explain _____

- **Are you taking any of the following?** ..... Yes No

Antibiotics or sulfa drugs.....	Yes	No	Aspirin.....	Yes	No
Anticoagulants (blood thinners).....	Yes	No	Nitroglycerin.....	Yes	No
High blood pressure medicine.....	Yes	No	Diet aids.....	Yes	No
Cortisone, Prednisone, Steroids.....	Yes	No	Birth control pills.....	Yes	No
Tranquilizers	Yes	No	Antidepressants.....	Yes	No

- **Do you take antibiotic pre-medication before dental treatment?** ..... Yes No
  For what reason? _____
- **Are you taking or have you taken Bisphosphonate medications to harden your bones?** Yes No
  (examples: Fosamax, Boniva, Actonel, and others) **Name**_____ **Dose**_____
- **Please list bellow all medications you are taking**

Name of medication	Dosage	Schedule	Name of Medication	Dosage	Schedule

- **Please circle yes for any of the following that you are allergic to**

Local anesthetic	Yes	No	Penicillin or other antibiotics.....	Yes	No
Sulfa drugs.....	Yes	No	Aspirin.....	Yes	No
Iodine, x-ray dyes or shellfish.....	Yes	No	Eggs or soybean products	Yes	No
Tape	Yes	No	Latex	Yes	No
Narcotic/opiate pain meds (Codeine, Vicodin, Percocet, Demerol)				Yes	No

- **Are you allergic to any medications?** ..... Yes No
- **Please list any medications you are allergic to**_____

- **Are you pregnant or have recently missed a period?** (women only)..... Yes No
- **Are you breast feeding?** (women only) ..... Yes No
- **Do you presently or have you ever regularly used tobacco products?**..... Yes No
  Cigarettes:_____PPD for_____years – Other types?_____
- **Have you ever had serious trouble with dental treatment?** ..... Yes No
  If so, please explain here_____
- **Please rank your level of anxiety below regarding dental surgery from 1 to 10**
  Least - 1 – 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 - Most
- Chief Dental complaint (why you came to the office today) _____

I VERIFY THE ACCURACY OF THE MEDICAL HISTORICAL INFORMATION ABOVE

_____ _____

Signature of Patient or Guardian of Patient **Date**

HEALTH HISTORY REVIEWED BY AND UPDATED BY PATIENT:

Date_____	Changes Y or N	Signature_____
Date_____	Changes Y or N	Signature_____
Date_____	Changes Y or N	Signature_____