MEDICAL HISTORY

*Patient name:*_____ *Today's Date:*_____

*Date of birth:*_____ *Age:*_____ *Height:*_____ *Weight:* _____

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.

*Date of last health care exam:*_____ *What was this exam for?*_____

Are you currently receiving care? (Please circle one) Yes No If yes, nature of care: _____

Have you ever had any serious illness, surgery or been hospitalized? (Please circle one) Yes No

If yes, reason: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

*1.*_____

*2.*_____

*3.*_____

*4.*_____

For the following medical conditions, circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health

Blood Pressure: (please circle one) High Low	*Yes* ☐ *No* ☐	*Stroke?*	*Yes* ☐ *No* ☐
Diabetes	*Yes* ☐ *No* ☐	*Sore/Enlarged Lymph Nodes*	*Yes* ☐ *No* ☐
Heart Disease, Angina, Heart Attack, Heart Surgery	*Yes* ☐ *No* ☐	*Fainting or Dizzy spells*	*Yes* ☐ *No* ☐
Heart Stent or Pacemaker, When placed? _____	*Yes* ☐ *No* ☐	*Kidney Disease*	*Yes* ☐ *No* ☐
Heart Valve (damaged/artificial) or Heart Transplant	*Yes* ☐ *No* ☐	*Renal Dialysis*	*Yes* ☐ *No* ☐
H.I.V. Infection AIDS or ARC	*Yes* ☐ *No* ☐	*Glaucoma*	*Yes* ☐ *No* ☐
Women: Are you pregnant	*Yes* ☐ *No* ☐	*Cancer or Tumor?*	*Yes* ☐ *No* ☐
Women: Are you trying to become pregnant	*Yes* ☐ *No* ☐	*Radiation or Chemotherapy?*	*Yes* ☐ *No* ☐
Asthma or other lung diseases	*Yes* ☐ *No* ☐	*Psychiatric or Mental Health Therapy*	*Yes* ☐ *No* ☐
Emphysema or COPD other Respiratory Illness	*Yes* ☐ *No* ☐	*Joint replacement? When Placed?*_____	*Yes* ☐ *No* ☐
Sleep Apnea	*Yes* ☐ *No* ☐	*Previous Bacterial Endocarditis*	*Yes* ☐ *No* ☐
Liver disease, Jaundice, or Cirrhosis	*Yes* ☐ *No* ☐	*Allergies? Sinus Trouble?*	*Yes* ☐ *No* ☐
Hepatitis (Any form)	*Yes* ☐ *No* ☐	*Slow-Healing mouth sores*	*Yes* ☐ *No* ☐
Arthritis, Rheumatism or other inflammatory disease	*Yes* ☐ *No* ☐	*Unintentional Weight Loss/Gain*	*Yes* ☐ *No* ☐
Blood Disorders? Abnormal bleeding from a cut?	*Yes* ☐ *No* ☐	*Previous Biopsies*	*Yes* ☐ *No* ☐
Congenital Heart Disease?	*Yes* ☐ *No* ☐	*Venereal Disease*	*Yes* ☐ *No* ☐
Thyroid Problems?	*Yes* ☐ *No* ☐	*Other Conditions*	*Yes* ☐ *No* ☐
Epilepsy or other neurological disease?	*Yes* ☐ *No* ☐	*If yes explain:*_____	
Is there any other problem you think we should know about?	*Yes* ☐ *No* ☐	*Other conditions*	*Yes* ☐ *No* ☐
_____		*If yes please list:*_____	

Are you taking any of these medications?

Pre-medication before dental treatment?	*Yes* ☐ *No* ☐	*Tagamet (Cimetidine) or Prilosec (omeprazole)?*	*Yes* ☐ *No* ☐
Antacids?	*Yes* ☐ *No* ☐	*Cardizem (diltiazem) or Calan, Isoptin (Verapamil)?*	*Yes* ☐ *No* ☐
St. John's Wort or Kava Kava?	*Yes* ☐ *No* ☐	*Serzone (nefazodone)*	*Yes* ☐ *No* ☐
Dilantin or Tegretol	*Yes* ☐ *No* ☐	*Diflucan (fluconazole) or Sporonox (itraconazole)*	*Yes* ☐ *No* ☐
Barbiturates (any)	*Yes* ☐ *No* ☐	*Biazin (clarithromycin)*	*Yes* ☐ *No* ☐

Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva, RECLAST) or PROLIA? *Yes* ☐ *No* ☐
If so, when did the treatment begin? _____ *When did the treatment end?* _____
Have you ever taken any prescription drugs such as fen-phen for weight loss? *Yes* ☐ *No* ☐
Do you consume grapefruit juice, grapefruits or grapefruit extract? *Yes* ☐ *No* ☐

Please list any medications you are currently taking and dosages:

*1.*_____ *2.* _____ *3.*_____

*4.*_____ *5.*_____ *6.*_____

*7.*_____ *8.*_____ *9.*_____

Please list any dietary or herbal supplements you are taking, and for what purpose:

*1.*_____ *2.*_____ *3.*_____

*4.*_____ *5.*_____ *6.*_____

OVER

Women:

Are you pregnant? *Yes* ☐ *No* ☐ *If no, are you planning a pregnancy in the future?* *Yes* ☐ *No* ☐

Are you a nursing mother? *Yes* ☐ *No* ☐ *Are you taking birth control pills?* *Yes* ☐ *No* ☐

Abnormal Blood Pressure? (Please circle) *Yes* ☐ *No* ☐

Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"? (Please circle one)

*What is your normal blood pressure?*_____/_____ *Today:* _____/_____

Are you allergic or have you had a reaction to:

Local anesthetics or epinephrine *Yes* ☐ *No* ☐

Penicillin or other antibiotics *Yes* ☐ *No* ☐

Aspirin, Ibuprofen, or Tylenol *Yes* ☐ *No* ☐

Codeine, Valium, Hydrocodone, Oxycodone or other sedatives *Yes* ☐ *No* ☐

Other (please specify) _____

*Chief Dental Complaint:*_____

_____

Have you had any trouble associated with any previous dental work? *Yes* ☐ *No* ☐ *If yes:*_____

Are you wearing any removable dental appliances? *Yes* ☐ *No* ☐

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, please circle type: Smoke Chew *Yes* ☐ *No* ☐ *How much per day?* _____ *For How long?*_____

Do you want to quit using tobacco? *Yes* ☐ *No* ☐

Do you consume alcohol? *Yes* ☐ *No* ☐ *If yes, approximately how many alcoholic beverages per week?* _____

Do you use any mood altering drugs other than those previously listed *Yes* ☐ *No* ☐

Diet Considerations

Sugar in your diet (please circle one)	*none*	*Slight*	*moderate*	*high*

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (print name) *Patient Signature* *Date*