04/12/2023

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

Aspirin ..... ○ Yes ○ No

Penicillin or other antibiotics ..... ○ Yes ○ No

Barbiturates, sedatives, or sleeping pills ..... ○ Yes ○ No

Sulfa drugs ..... ○ Yes ○ No

Codeine or other narcotics ..... ○ Yes ○ No

Metals ..... ○ Yes ○ No

Latex (rubber) ..... ○ Yes ○ No

Iodine ..... ○ Yes ○ No

Hay fever/seasonal ..... ○ Yes ○ No

Animals ..... ○ Yes ○ No

Food ..... ○ Yes ○ No

Other ..... ○ 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

Previous infective endocarditis ..... ○ Yes ○ No

Damaged valves in transplanted heart ..... ○ Yes ○ No

Congenital heart disease (CHD) ..... ○ Yes ○ No

Unrepaired, cyanotic CHD ..... ○ 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

Angina ..... ○ Yes ○ No

Arteriosclerosis ..... ○ Yes ○ No

Congestive heart failure ..... ○ Yes ○ No

Damaged heart valves ..... ○ Yes ○ No

Heart attack ..... ○ Yes ○ No

Heart murmur ..... ○ Yes ○ No

Low blood pressure ..... ○ Yes ○ No

High blood pressure ..... ○ 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 _____

_____

Signature of Patient/Legal Guardian