12/04/2019

Medical History Form

Patient Name: _____ Emergency Contact _____

Date of Birth: _____ Emergency Contact Phone _____

Sex: _____ 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