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 _____

_____

Signature of Patient/Legal Guardian