06/23/2022

# 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 | Arthritis ..... | Yes | No |
| Angina ..... | Yes | No | Autoimmune disease ..... | Yes | No |
| Arteriosclerosis ..... | Yes | No | Rheumatoid arthritis ..... | Yes | No |
| Congestive heart failure ..... | Yes | No | Systemic lupus erythematosus ..... | Yes | No |
| Damaged heart valves ..... | Yes | No | Asthma ..... | Yes | No |
| Heart attack ..... | Yes | No | Bronchitis ..... | Yes | No |
| Heart murmur ..... | Yes | No | Emphysema ..... | Yes | No |
| Low blood pressure ..... | Yes | No | Sinus trouble ..... | Yes | No |
| High blood pressure ..... | Yes | No | Tuberculosis ..... | Yes | No |
| Other congenital heart defects ..... | Yes | No | Cancer/Chemotherapy/Radiation Treatment | Yes | No |
| Mitral valve prolapse ..... | Yes | No | Chest pain upon exertion ..... | Yes | No |
| Pacemaker ..... | Yes | No | Chronic pain ..... | Yes | No |
| Rheumatic fever ..... | Yes | No | Diabetes Type I or II ..... | Yes | No |
| Rheumatic heart disease ..... | Yes | No | Eating disorder ..... | Yes | No |
| Abnormal bleeding ..... | Yes | No | Malnutrition ..... | Yes | No |
| Anemia ..... | Yes | No | Gastrointestinal disease ..... | Yes | No |
| Blood transfusion ..... | Yes | No | G.E. Reflux/persistent heartburn ..... | Yes | No |
| If yes, date _____ | | | Thyroid problems ..... | Yes | No |
| Hemophilia ..... | Yes | No | Stroke ..... | Yes | No |
| AIDS or HIV ..... | 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