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			**Unrepaired, cyanotic CHD** .... ○ Yes ○ No		
Previous infective endocarditis .... ○ Yes ○ No			**Repaired (completely) in the last 6 months** .. ○ Yes ○ No		
Damaged valves in transplanted heart .... ○ Yes ○ No			**Repaired CHD with residual defects** .... ○ Yes ○ No		
Congenital heart disease (CHD) .... ○ Yes ○ No					

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease .... ○ Yes ○ No			**Blood transfusion** .... ○ Yes ○ No		
Angina .... ○ Yes ○ No			**If yes, date** _____		
Arteriosclerosis .... ○ Yes ○ No			**Hemophilia** .... ○ Yes ○ No		
Congestive heart failure .... ○ Yes ○ No			**AIDS or HIV** .... ○ Yes ○ No		
Damaged heart valves .... ○ Yes ○ No			**Arthritis** .... ○ Yes ○ No		
Heart attack .... ○ Yes ○ No			**Autoimmune disease** .... ○ Yes ○ No		
Heart murmur .... ○ Yes ○ No			**Rheumatoid arthritis** .... ○ Yes ○ No		
Low blood pressure .... ○ Yes ○ No			**Systemic lupus erythematosus** .... ○ Yes ○ No		
High blood pressure .... ○ Yes ○ No			**Asthma** .... ○ Yes ○ No		
Other congenital heart defects .... ○ Yes ○ No			**Bronchitis** .... ○ Yes ○ No		
Mitral valve prolapse .... ○ Yes ○ No			**Emphysema** .... ○ Yes ○ No		
Pacemaker .... ○ Yes ○ No			**Sinus trouble** .... ○ Yes ○ No		
Rheumatic fever .... ○ Yes ○ No			**Tuberculosis** .... ○ Yes ○ No		
Rheumatic heart disease .... ○ Yes ○ No			**Cancer/Chemotherapy/Radiation Treatment** .... ○ Yes ○ No		
Abnormal bleeding .... ○ Yes ○ No			**Chest pain upon exertion** .... ○ Yes ○ No		
Anemia .... ○ Yes ○ No			**Chronic pain** .... ○ Yes ○ No		

Diabetes Type I or II	⚪ Yes ⚪ No	**Sleep disorder**	⚪ Yes ⚪ No
Eating disorder	⚪ Yes ⚪ No	**Mental health disorders**	⚪ Yes ⚪ No
Malnutrition	⚪ Yes ⚪ No	**Specify** _____	
Gastrointestinal disease	⚪ Yes ⚪ No	**Recurrent infections**	⚪ Yes ⚪ No
G.E. Reflux/persistent heartburn	⚪ Yes ⚪ No	**Type of infection** _____	
Thyroid problems	⚪ Yes ⚪ No	**Kidney problems**	⚪ Yes ⚪ No
Stroke	⚪ Yes ⚪ No	**Night sweats**	⚪ Yes ⚪ No
Glaucoma	⚪ Yes ⚪ No	**Osteoporosis**	⚪ Yes ⚪ No
Hepatitis, jaundice or liver disease	⚪ Yes ⚪ No	**Persistent swollen glands in neck**	⚪ Yes ⚪ No
Epilepsy	⚪ Yes ⚪ No	**Severe headaches/migraines**	⚪ Yes ⚪ No
Fainting spells or seizures	⚪ Yes ⚪ No	**Severe or rapid weight loss**	⚪ Yes ⚪ No
Neurological disorders	⚪ Yes ⚪ No	**Sexually transmitted disease**	⚪ Yes ⚪ No
If yes, please specify _____		**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