

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 bisphosphonates (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