2015 Medical Hx

Patient Name: Birth Date: Date Created:

Although dental professionals primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you take could have an important interrelationship with the dentistry that you receive. Thank you for answering the following questions!

Please list name of Primary Physician and any Specialists you see. Also please list last date of service for each.

Have you been hospitalized or had a major operation in the LAST 5 YEARS?	○ Yes ○ No	If yes
Do you take, or have you taken Phen-fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other Bisphosphonate? If yes, oral or injectable?	○ Yes ○ No	If yes
Do you use tobacco/nicotene products or alcohol now or in the past? For how long?	○ Yes ○ No	If yes
If yes to question above, are you interested in	○ Yes ○ No	If yes
Do you use controlled substances now or in the	○ Yes ○ No	If yes
Do you take premedication before dental treatment for an artificial joint or heart issue?	○ Yes ○ No	If yes
Have you been diagnosed with Sleep Apnea? Do you have a sleep appliance?	○ Yes ○ No	If yes

Please list all medications you take including OTC and Vitamins

Women: are you....

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs
☐ Local Anesthetics ☐ Metals/alloys ☐ Latex

Any other Allergies not listed? ☐ If yes

Do you have, or have had, any of the following?

Angina/Chest Pains	○ Yes ○ No	Blood Disease including Hemophilia	○ Yes ○ No	Liver Disease	○ Yes ○ No
Artificial Heart Valve/Joint Replacement	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Shingles	○ Yes ○ No
Heart Attack/Failure	○ Yes ○ No	Anemia/Sickle Cell Disease	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Leukemia	○ Yes ○ No	Pacemaker	○ Yes ○ No
High or Low Blood Pressure	○ Yes ○ No	Breathing Disorder	○ Yes ○ No	Epilepsy, Seizures, or Convulsions	○ Yes ○ No
Heart Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No	HIV/AIDS	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Stroke	○ Yes ○ No	Hepatitis A, B, or C	○ Yes ○ No
Diabetes, Excessive Thirst, Recent Weigh	○ Yes ○ No	Restless leg Sydrome	○ Yes ○ No	STD's	○ Yes ○ No
Glaucoma or Eye Issues	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Bruising or Excessive Bleeding	○ Yes ○ No
Renal Disease/Dialysis	○ Yes ○ No	Cancer or Tumors/Radiation or Chemothera	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Difficulty Hearing	○ Yes ○ No	Autoimmune Disease	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No
Stomach/Intestinal/Ulcers	○ Yes ○ No	Phsyciatric Care	○ Yes ○ No	Erectile Dysfunction	○ Yes ○ No
Anxiety/Depression	○ Yes ○ No	Sleep Issue/Daytime Sleepiness	○ Yes ○ No	Drug/Alcohol Treament	○ Yes ○ No

Have you ever had any serious illness not listed ☐ If yes

Comments: Please explain all YES answers from above list

Family History

Do you have a family history of any of the following: (Please specify relationship ie. spouse/partner, parent, sibling, grandparent)

Heart Attack/Failure	○ Yes ○ No	If yes
Heart Disease	○ Yes ○ No	If yes
High Blood Pressure	○ Yes ○ No	If yes
Stroke	○ Yes ○ No	If yes
Alzheimer's	○ Yes ○ No	If yes
Cancer/Tumor	○ Yes ○ No	If yes
Diabetes (type)	○ Yes ○ No	If yes
Autoimmune Disorder	○ Yes ○ No	If yes
Sleep Disorder	○ Yes ○ No	If yes

Vital Signs

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____