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 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

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