# MEDICAL HISTORY

***Name*** _____ ***Birth date*** _____

***Please circle any of the following which you have or have had in the past***

Do you require antibiotics before dental treatment? Y N

**PRE-MED DOSEAGE** _____

Y N Heart Conditions (Murmur, Rheumatic heart disease, Congenital defect, Mitral Valve Prolapse, Coronary artery disease, Irregular heart beat, Congestive heart failure) , Heart Attack or other _____

_____

Y N Chest Pain (Angina)

Y N Heart Procedures – Stents, Catheterization, Angioplasty, Pacemaker, Bypass surgery, Prosthetic valve placement.

Type and Date of surgery _____

_____

Y N Stroke / TIA's Date: _____

Y N High Blood Pressure

Y N Blood Transfusions- Date _____

Y N Blood disorders (anemia, bleeding tendencies, etc)

Y N Stomach or Intestinal disease (GERD, Ulcers, Colitis, Diverticulitis, Hernia, Hiatal hernia)

Y N Diabetes (or family history of)

Date Diagnosed _____

Glucose level _____

Y N Cancer, Tumors, or Growths (include skin, benign etc)

Type diagnosed _____

Treatment _____

Y N Radiation therapy (X-ray treatments for Cancer)

Area of Treatment _____

Dose amount _____

Y N Chemotherapy Treatment for Cancer

Date of Treatment _____

Length of Treatment _____

Y N Fainting spells / Vertigo

Y N Frequent headaches or earaches

Y N TMJ (Jaw joint) problems or limited opening of mouth

Appliance? _____

Y N Organ Transplant _____

Date of Transplant: _____

Y N Kidney Disease / Stones

Y N Autoimmune disease such as Lupus, Pemphigus, Pemphigoid, Lichen Planus

Y N Pregnant or breast-feeding currently (Women only)

Y N Are you past Menopause (Women only)

Y N Glaucoma

Y N Thyroid Disease

Y N Liver Disease (Cirrhosis, Hepatitis, Etc)

Y N Respiratory (Lung) Disease (Emphysema, Asthma, COPD, Tuberculosis, etc)

Y N Cortisone or steroid type medications

Y N Prosthetic joints or valves (Hip replacements, etc)

Type/Date_____

Y N Seizure Disorder (Epilepsy, traumatic)

Y N Arthritis (Rheumatoid, Osteo, Fibromyalgia, Gout)

Y N Allergies (hay fever, foods, materials, or medications)

_____

_____

Y N Sinus Problems

Y N Loss of Weight (without dieting)

Y N History of Surgery, especially several repeated Procedures in childhood

Y N Are you allergic to or unable to eat bananas, kiwis, avocados, chestnuts, tomatoes, potatoes, or hazelnuts?

Y N Do you have a heavy persistent cough of 2-3 weeks duration, particularly one that brings up sputum or bloodied sputum?

Y N Infectious disease (AIDS, HIV, Herpes, Syphilis, Tuberculosis, Hepatitis A, B, or C or other)

Y N Substance abuse (alcohol, cocaine, drugs, etc)

Y N Do you take or have you ***ever*** taken any of the following: If yes for how Long? _____

Fosamax or Fosamax plus D (Alendronate), Actonel (Risedronate), Boniva (Ibandronate) Zometa (Zolendronic acid), Didronel (Etidronate disodium) Didrocal, Aredia (Pamidronate), Bonefos (Clondronate), Skelid (Tiludronate), Forteo (Teriparatide)

Y N Other _____

**Have you experienced an allergic or unusual reaction to any of the following?**

| | | | |
|---|---|---|---|
| ___Aspirin | ___Sulfa drugs | ___Penicillin | ___Erythromycin |
| ___Tetracycline | ___Barbiturates | ___Pain medication | ___Acetaminophen |
| ___Ibuprofen | ___Latex | ___Local anesthetic (Novocain) | ___Codeine |

Please list any other drugs or materials that you are allergic to: _____

***Name*** _____ BP: _____/_____ Pulse _____

*Date:* _____*initials:* _____

# Continued Medical History

Your current physical health is: ___Excellent ___ Good ____ Fair ____ Poor

Are you currently under the care of a physician? Y N Please explain: _____

Please list all physicians and their specialty

Family physician: _____
Address: _____
Phone: _____

Physician: _____
Specialty: _____
Address: _____
Phone: _____

Physician: _____
Specialty: _____
Address: _____
Phone: _____

Physician: _____
Specialty: _____
Address: _____
Phone: _____

**List <u>ALL</u> medications you are taking and reason. Include prescription, supplements, and over the counter.** *(Include any blood thinning herbal medications or supplements such as: Vitamin E, garlic, fish oil, any oils, bilberry, bromelain, cat's claw, devil's claw, dong quai, evening primrose, feverfew, ginger (at high doses), ginkgo biloba, grape seed, ginseng, green tea, horse chestnut, and turmeric.)*

| | **<u>Name of Medication</u>** | **<u>Dosage</u>** | **<u>Reason</u>** |
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*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

_____

Signature Date

***Name*** _____ ***Date***_____

# DENTAL HISTORY

Y N Did you visit your dentist within the last year?

How often do you have your teeth cleaned? _____

Last cleaning date _____

Y N Are you dissatisfied with the appearance of your teeth?

Y N Are you worried about having dental treatment?

Y N Would it bother you to lose your teeth?

Y N Would you be tremendously disturbed if you had to wear artificial teeth?

Y N Do your gums bleed easily?

Y N Do your gums feel tender?

Y N Does your mouth feel dry?

Y N Do you have difficulty swallowing?

Y N Do you clench or grind your teeth during the day or night?

Y N Do your teeth feel loose?

Y N Does your lower jaw click, snap, pop, or jump when you open?

Y N Are your teeth sensitive to hot, cold, or sweets?

Y N Do you use an electric Toothbrush? Brand _____

Y N Have you ever had orthodontic treatment? Date _____

Y N Have you ever had periodontal treatment? Date _____

Type – _____

Areas Treated _____

Y N Are you on any special diet? Explain _____

Y N Do you use tobacco in any form? Type_____

How Long ? _____

***Special Considerations***

*Office Use Only*