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

Patient's Name: ______________________

Allergies, Are you allergic to or have you had any reaction to

Item	Yes	No
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:

Item	Yes	No
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:

Item	Yes	No
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

Patient's Name: ______________________________

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 ____

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Signature of Patient/Legal Guardian