06/27/2023

Medical History Form

Patient Name: _____ Emergency Contact _____

Date of Birth: _____ Emergency Contact Phone _____

Gender: (For Insurance Purposes) Male Female 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
- **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