

Medical History 2014

Patient Name:

Birth Date:

Date Created:

Have you ever been told you need to premedicate for dental treatment?  Yes  No If yes

Are you under a physician's care now?  Yes  No If yes

Have you ever been hospitalized or had a major operation?  Yes  No If yes

Have you ever had a serious head or neck injury?  Yes  No If yes

Are you taking any medications, pills, or drugs?  Yes  No If yes

Have you taken Bisphosphonates?  Yes  No

Do you use tobacco? If so, do you smoke, chew or use E Cigarettes?  Yes  No If yes

What is the name of your medical clinic?

Women: Are you...

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

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Metal

Latex  Sulfa Drugs  Local Anesthetics

Other Allergies?  Yes  No If yes

Sleep Apnea:

Do you snore?  Yes  No

Do you feel sleepy during the daytime?  Yes  No

Is your snoring bothering your bed partner?  Yes  No

Do you use or have you been recommended to use a CPAP?  Yes  No

Do you have or ever been diagnosed with any of the following?

Alcohol Addiction <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	AIDS/ HIV Positive <input type="radio"/> Yes <input type="radio"/> No
Eating Disorder / Anorexia / Bulimia <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Pain in the Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No
Emphysema <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash/ Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Steroid Medicine <input type="radio"/> Yes <input type="radio"/> No	Arthritis <input type="radio"/> Yes <input type="radio"/> No
Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No
Fainting Spells / Dizziness <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble / Disease <input type="radio"/> Yes <input type="radio"/> No	Stomach / Intestinal Disease/ IBS <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Autism / Asbergers <input type="radio"/> Yes <input type="radio"/> No
Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Heart Attack / Failure <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No	Breathing Problems <input type="radio"/> Yes <input type="radio"/> No
Gout <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Bruise Easily <input type="radio"/> Yes <input type="radio"/> No
Hay Fever / Allergies <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Parkinsons <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No
Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy / Radiation <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B <input type="radio"/> Yes <input type="radio"/> No
Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Cold Sores / Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Hepatitis C <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No
Diabetes I or II <input type="radio"/> Yes <input type="radio"/> No	Hearing Disorder <input type="radio"/> Yes <input type="radio"/> No	Mental Health <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed?  Yes  No If yes

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date: \_\_\_\_\_