

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?		
Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement?		
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 Anemia ☐ Yes ☐ No

Angina ☐ Yes ☐ No Blood transfusion ☐ Yes ☐ No

Arteriosclerosis ☐ Yes ☐ No If yes, date _____

Congestive heart failure ☐ Yes ☐ No Hemophilia ☐ Yes ☐ No

Damaged heart valves ☐ Yes ☐ No AIDS or HIV ☐ Yes ☐ No

Heart attack ☐ Yes ☐ No Arthritis ☐ Yes ☐ No

Heart murmur ☐ Yes ☐ No Autoimmune disease ☐ Yes ☐ No

Low blood pressure ☐ Yes ☐ No Rheumatoid arthritis ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No Systemic lupus erythematosus ☐ Yes ☐ No

Other congenital heart defects ☐ Yes ☐ No Asthma ☐ Yes ☐ No

Mitral valve prolapse ☐ Yes ☐ No Bronchitis ☐ Yes ☐ No

Pacemaker ☐ Yes ☐ No Emphysema ☐ Yes ☐ No

Rheumatic fever ☐ Yes ☐ No Sinus trouble ☐ Yes ☐ No

Rheumatic heart disease ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No

Abnormal bleeding ☐ 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