Medical History

Patient Name:_____ Date of Birth: _____

Are you in good health?_____ Are you under medical care?_____

Physicians: _____ Approximate date last seen: _____

_____ _____

_____ _____

Approximate date of last physical examination?_____

Medications that you take on a regular basis? If none, check ❑

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications that you believe you should avoid? If none, check ❑

(itching, hives, breathing impairment, nausea, drowsiness, euphoria, dysphoria, dizziness cr syncope)

❑ penicillin _____ ❑ aspirin _____

❑ erythromycin_____ ❑ acetominophen_____

❑ tetracycline_____ ❑ narcotics_____

❑ other antibiotics: _____ ❑ other drugs:_____

_____ _____

Have you ever taken a bisphosphonate (Fosamax, Boniva, Aredia, etc.) for osteoporosis or bone cancer?

_____

Steroids [cortisone, etc.] taken during past 12 months?_____

Prolonged illness and hospitalization experience during past 5 years:

_____

_____

Cardiovascular system: [circle "items" you've experienced] If none, check ❑

1. murmur
2. rheumatic heart disease [RHD]
3. prosthetic heart valve
4. heart surgery
5. arrythmia [irregular heartbeat]
6. angina
7. congestive heart failure
8. heart attack [MI]
9. prosthetic joint (knee, hip)
10. cardiac pacemaker
11. "mini-stroke" [TIA}
12. "stroke" [CVA]
13. hypertension/hypotension
14. other

_____

_____

History of significant disorders: [circle...] If none, check ❑

17. diabetes
18. estrogen replacement
19. hormonal [other]
20. osteoporosis
21. rheumat. arthritis
22. tuberculosis
23. bronchitis
24. asthma
25. sinusitis
26. other respiratory
27. epilepsy
28. hepatitis
29. liver disease [other]
30. hemophilia
31. bleeding [other]
32. cancer
33. HIV/AIDS
34. clicnical depression
35. other psychiatric
36. other disorder

_____

_____

Current medical symptoms: [circle...] If none, check ❑

37. frequent cough
38. persistent fever
39. faintness/dizziness
40. weakness
41. excessive thirst
42. malaise
43. excessive fatigue
44. difficulty sleeping

_____

_____

Tobacco use: cigarettes/cigars____ [pks/day] pipe____ [pipes/day] snuff____[area]

Alcohol use: how often?_____ how much?_____

Pregnant? _____ [due date_____] Postmenopausal?_____

Other health information of concern?_____

_____

At each dental appointment please advise us of changes in your health status.
(e.g. pregnancy, cardiac distress, hospitalization, prolonged illness,...)

Patient/guardian signature: _____ **Date:**_____

Thank you for helping us to help you

Reviewed by:	**Premed. indicated?**	**Date:**