MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth:_____

For the following questions please circle Yes or No. Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. My physician is:_____Telephone Number_____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. Are you taking or have you ever taken Bisphosphonate Medications for osteoporosis or chemotherapy for multiple myeloma or other cancers (this would include drugs such as Fosamax, Actonel, Boniva, Aredia or Zometa)? ..... Yes No
9. Are you taking any blood thinners such as aspirin, Plavix, or Coumadin?…….. ..... Yes No
10. **Please list all medications that you take.**
    Including over the counter medications, vitamins, natural supplements and/or diet pills

    _____

    _____
11. **Are you allergic to or have had a reaction to**: **Please Circle**
    a. Local Anesthetics…… Yes No
    b. Penicillin…… Yes No
    c. Sulfa Drugs …… Yes No
    d. Codeine or other Pain Medications …… Yes No
    e. Barbiturates or Sleeping Pills …… Yes No
    f. Aspirin …… Yes No
    g. Iodine …… Yes No
    h. Latex or Rubber Products …… Yes No
    I. Other (please list)…… Yes No
12. **Do you have or have you had any of the following? Please circle which condition.**
    a. Heart Murmur, Damaged or Artificial Valves, Mitral Valve Prolapse ..... Yes No
    b. Rheumatic Heart Disease ..... Yes No
    c. High Blood Pressure, Heart trouble, Heart attack, Angina, Stroke, Arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. Seasonal Allergies ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma or hay fever ..... Yes No
    g. Fainting spells or seizures ..... Yes No
    h. Diabetes ..... Yes No
    i. Hepatitis, jaundice or liver disease ..... Yes No
    j. Frequent or recurring mouth sores ..... Yes No
    k. Thyroid problems ..... Yes No

l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
n. Osteoporosis ..... Yes No

o. Stomach ulcer or hyperacidity ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough that produces blood ..... Yes No
s. Persistent swollen neck glands ..... Yes No
t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer ..... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

13. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
14. Do you have any blood disorder such as anemia? ..... Yes No
15. Have you ever had treatment for a tumor or growth? ..... Yes No
16. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain:_____
    _____
18. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain:_____
19. When was you last dental treatment? _____ Last X-rays?_____
20. What did you have done?_____
21. How many times a day do you brush? _____ Floss?_____
22. Do you smoke or chew Tobacco? ..... Yes No
23. Have you ever had gum treatment or seen a Periodontist? ..... Yes No
24. Do you wear a removable dental appliance?_____ Age of appliance?_____
25. Are you happy with the appearance of you teeth? ..... Yes No
26. Interested in any smile improvements? (Bleaching, tooth replacement, orthodontics) ..... Yes No
27. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
28. Are you wearing contact lenses? ..... Yes No
29. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

30. Are you pregnant or trying to become pregnant? ..... Yes No
31. Are you nursing? ..... Yes No
32. Are you taking birth control pills? ..... Yes No

If you are using Oral contraceptives it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. If you are prescribed antibiotics, you will need to use mechanical forms of birth control until one complete cycle of pills is finished. Consult with your physician for further guidance.

I have read and understand the above. Any questions I had about this form have been answered and

I understand the answers. I understand it is my responsibility to fill out the form correctly and completely. Furthermore, I certify that I understand and consent to the performing of dental and oral surgery procedures agreed to be necessary or advised including the use of local anesthetic & / or Nitrous oxide sedation. I assume responsibility for fees associated with any dental procedures.

Sign_____ Date_____