Medical History Form

Patient Name:

Date of Birth:

Sex:

Emergency Contact ______________________

Emergency Contact Phone ______________________

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

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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	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	Congenital heart disease (CHD)	Yes	No
Previous infective endocarditis	Yes	No	Unrepaired, cyanotic CHD	Yes	No
Damaged valves in transplanted heart	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	Blood transfusion	Yes	No
Angina	Yes	No	If yes, date ______________________		
Arteriosclerosis	Yes	No	Hemophilia	Yes	No
Congestive heart failure	Yes	No	AIDS or HIV	Yes	No
Damaged heart valves	Yes	No	Arthritis	Yes	No
Heart attack	Yes	No	Autoimmune disease	Yes	No
Heart murmur	Yes	No	Rheumatoid arthritis	Yes	No
Low blood pressure	Yes	No	Systemic lupus erythematosus	Yes	No
High blood pressure	Yes	No	Asthma	Yes	No
Other congenital heart defects	Yes	No	Bronchitis	Yes	No
Mitral valve prolapse	Yes	No	Emphysema	Yes	No
Pacemaker	Yes	No	Sinus trouble	Yes	No
Rheumatic fever	Yes	No	Tuberculosis	Yes	No
Rheumatic heart disease	Yes	No	Cancer/Chemotherapy/Radiation Treatment	Yes	No
Abnormal bleeding	Yes	No	Chest pain upon exertion	Yes	No
Anemia	Yes	No	Chronic pain	Yes	No

Condition	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