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 ..... No Yes

Persistent cough greater than a 3 week duration ..... No Yes

Cough that produces blood ..... No Yes

Been exposed to anyone with tuberculosis ..... No Yes

Medical History

Are you now under the care of a physician? ..... No Yes

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? ..... No Yes

Has there been any change in your general health within the past year? ..... No Yes

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? ..... No Yes

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... No Yes

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Do you wear contact lenses? ..... No Yes

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

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? No Yes

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? No Yes

Date Treatment began _____

Do you use controlled substances (drugs)? ..... No Yes

Do you use tobacco (smoking, snuff, chew, bidis)? ..... No Yes

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? ..... No Yes

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 ..... No Yes

Number of weeks _____

Taking birth control pills or hormonal replacement? ..... No Yes

Nursing? ..... No Yes

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics	Yes	No	Iodine	Yes	No
Aspirin	Yes	No	Hay fever/seasonal	Yes	No
Penicillin or other antibiotics	Yes	No	Animals	Yes	No
Barbiturates, sedatives, or sleeping pills	Yes	No	Food	Yes	No
Sulfa drugs	Yes	No	Other	Yes	No
Codeine or other narcotics	Yes	No	If Other, please specify:		
Metals	Yes	No	_____		
Latex (rubber)	Yes	No			

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	High blood pressure	Yes	No
Angina	Yes	No	Other congenital heart defects	Yes	No
Arteriosclerosis	Yes	No	Mitral valve prolapse	Yes	No
Congestive heart failure	Yes	No	Pacemaker	Yes	No
Damaged heart valves	Yes	No	Rheumatic fever	Yes	No
Heart attack	Yes	No	Rheumatic heart disease	Yes	No
Heart murmur	Yes	No	Abnormal bleeding	Yes	No
Low blood pressure	Yes	No	Anemia	Yes	No

Blood transfusion ..... Yes No

If yes, date _____

Hemophilia ..... Yes No

AIDS or HIV ..... Yes No

Arthritis ..... Yes No

Autoimmune disease ..... Yes No

Rheumatoid arthritis ..... Yes No

Systemic lupus erythematosus ..... Yes No

Asthma ..... Yes No

Bronchitis ..... Yes No

Emphysema ..... Yes No

Sinus trouble ..... Yes No

Tuberculosis ..... 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