MEDICAL HISTORY

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA OF THE MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

1. ARE YOU IN GOOD HEALTH?............................ YES NO
2. ANY CHANGES IN YOUR GENERAL HEALTH
3. WITHIN THE PAST YEAR?.................................. YES NO
3. DATE OF YOUR LAST PHYSICAL EXAM________________
4. PHYSICIAN'S NAME:__________________________________
5. HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE LAST FIVE YEARS?................................ YES NO
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?.. YES NO
7. HAVE YOU EVER HAD ANY ABNORMAL BLEEDING? YES NO
8. DO YOU BRUISE EASILY?................................. YES NO
9. HAVE YOU EVER HAD A BLOOD TRANSFUSION?... YES NO
10. HAVE YOU HAD RECENT WEIGHT LOSS?...... YES NO
11. HAVE YOU EVER TAKEN FEN-PEN OR REDUX?...... YES NO
12. DO YOU USE TOBACCO?................................ YES NO
13. DO YOU OR HAVE YOU ILLEGALLY USED CONTROLLED SUBSTANCES?......................... YES NO
14. DO YOU WEAR CONTACT LENSES?................ YES NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

ASTHMA.. YES NO
HAY FEVER.. YES NO
EMPHYSEMA, CHRONIC COUGH, PNEUMONIA, TUBERCULOSIS, OR ANY OTHER LUNG DISORDER... YES NO
HIVES OR SKIN RASH.................................... YES NO
SINUS TROUBLE.. YES NO
ALLERGIES.. YES NO
RHEUMATIC HEART DISEASE........................... YES NO
SCARLET FEVER.. YES NO
HEART DEFECT OR HEART MURMUR................. YES NO
HEART TROUBLE, ATTACK OR ANGINA.............. YES NO
HEART SURGERY.. YES NO
PACEMAKER.. YES NO
MITRAL VALVE PROLAPSE.............................. YES NO
CONGENITAL HEART PROBLEM........................ YES NO
CHEST PAIN... YES NO
SHORTNESS OF BREATH................................ YES NO
STROKE.. YES NO
ATHEROSCLEROSIS....................................... YES NO
ANEMIA.. YES NO
HIGH BLOOD PRESSURE................................ YES NO
LOW BLOOD PRESSURE................................. YES NO
SICKLE CELL DISEASE.................................. YES NO
HEMOPHILIA.. YES NO
GLAUCOMA... YES NO
DIABETES... YES NO
HYPOGLYCEMIA.. YES NO
KIDNEY TROUBLE OR DISEASE....................... YES NO
THYROID PROBLEMS..................................... YES NO
CHOLESTEROL PROBLEMS............................ YES NO

COLD SORES/FEVER BLISTERS........................ YES NO
STOMACH ULCERS.. YES NO
LIVER DISEASE... YES NO
HEPATITIS A, B, C, D, JAUNDICE...................... YES NO
AIDS OR HIV INFECTION................................. YES NO
FAINTING OR DIZZINESS................................ YES NO
EPILEPSY OR SEIZURES................................ YES NO
MENTAL HEALTH CARE.................................. YES NO
TREATED FOR ANXIETY.................................. YES NO
EATING DISORDER (BULIMIA/ANOREXIA).......... YES NO
CHEMICAL DEPENDENCY................................ YES NO
CORTISONE TREATMENT................................ YES NO
CHEMOTHERAPY (CANCER, LEUKEMIA)............ YES NO
ARTHRITIS OR RHEUMATISM........................... YES NO
SWELLING OF FEET, ANKLES OR HANDS........... YES NO
JOINT REPLACEMENT OR IMPLANT.................. YES NO
BACK PROBLEMS.. YES NO
JAW PAIN... YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO:

LOCAL ANESTHETICS LIKE NOVOCAINE............ YES NO
PENICILLIN... YES NO
OTHER ANTIBIOTICS...................................... YES NO
SULFA DRUGS.. YES NO
BARBITURATES, SEDATIVES, OR SLEEPING PILLS...... YES NO
ASPIRIN... YES NO
IODINE... YES NO
CODEINE.. YES NO
ANY METALS (NICKEL, MERCURY, ETC.)............ YES NO
LATEX/RUBBER... YES NO
OTHER?____

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT?.. YES NO

IF SO, WHAT?______________________________________

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	STRENGTH	QTY

HEIGHT_______________ **WEIGHT**_______________

WOMEN ONLY:
ARE YOU PREGNANT OR THINK YOU MAY BE?............. YES NO
ARE YOU NURSING?.. YES NO
ARE YOU TAKING BIRTH CONTROL PILLS?.................. YES NO

SIGNATURE OF RESPONSIBLE PARTY:______________________________ **DATE:**______________