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	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 _____		
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

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