Medical History Form

Patient Name: _____ **Emergency Contact:** _____
Date of Birth: _____ **Emergency contact Phone:** _____
Sex: _____ **Emergency Contact Relation:** _____

Do you have any of the following diseases or problems

Active tuberculosis	Yes	No
Persistent cough greater than a 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) risedronate (Actonel®) osteoporosis or Paget's disease? Yes No
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting form 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? _____

Medical History Form

WOMEN ONLY, Are you:

Pregnant ..... ◯ Yes ◯ No

Number of week's _____

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

Aspirin ..... ◯ Yes ◯ No

Penicillin or other antibiotics ..... ◯ Yes ◯ No

Barbiturates, sedatives, or sleeping pills ..... ◯ Yes ◯ No

Sulfa drugs ..... ◯ Yes ◯ No

Codeine or other narcotics ..... ◯ Yes ◯ No

Metals ..... ◯ Yes ◯ No

Latex (rubber) ..... ◯ Yes ◯ No

Iodine ..... ◯ Yes ◯ No

Hay fever/seasonal ..... ◯ Yes ◯ No

Animals ..... ◯ Yes ◯ No

Food ..... ◯ Yes ◯ No

Other ..... ◯ 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

Previous infective endocarditis ..... ◯ Yes ◯ No

Damaged valves in transplanted heart ..... ◯ Yes ◯ No

Congenital heart disease (CHD) ..... ◯ Yes ◯ No

Unrepaired, cyanotic CHD ..... ◯ Yes ◯ No

Repaired (completely) in the last 6 Months ..... ◯ Yes ◯ No

Repaired CHD with residual defects..... ◯ Yes ◯ No

Other Disease and conditions – please indicate if you have had or not had Any of the following:

Cardiovascular disease ..... ◯ Yes ◯ No

Angina ..... ◯ Yes ◯ No

Arteriosclerosis ..... ◯ Yes ◯ No

Congestive heart failure ..... ◯ Yes ◯ No

Damaged heart valves ..... ◯ Yes ◯ No

Heart attack ..... ◯ Yes ◯ No

Heart murmur ..... ◯ Yes ◯ No

Low blood pressure ..... ◯ Yes ◯ No

High blood pressure ..... ◯ Yes ◯ No

Other congenital heart defects ..... ◯ Yes ◯ No

Mitral valve prolapse ..... ◯ Yes ◯ No

Pacemaker ..... ◯ Yes ◯ No

Rheumatic fever ..... ◯ Yes ◯ No

Rheumatic heart disease ..... ◯ Yes ◯ No

Abnormal Bleeding ..... ◯ Yes ◯ No

Anemia ..... ◯ Yes ◯ No

Diabetes Type I or II ..... ◯ Yes ◯ No

Eating disorder ..... ◯ Yes ◯ No

Malnutrition ..... ◯ Yes ◯ No

Gastrointestinal disease ..... ◯ 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

Sleep disorder ..... ◯ Yes ◯ No

Mental health disorder ..... ◯ Yes ◯ No

Specify _____

Recurrent infections ..... ◯ Yes ◯ No

Medical History Form

G.E Reflux/persistent heartburn	Yes	No	Type of infection	Yes	No
Thyroid problems	Yes	No	Kidney problems	Yes	No
Stroke	Yes	No	Night sweats	Yes	No
Glaucoma	Yes	No	Osteoporosis	Yes	No
Hepatitis, jaundice or lever disease	Yes	No	Persistent swollen glands in neck	Yes	No
Epilepsy	Yes	No	Severe headaches/migraines	Yes	No
Fainting spells or seizures	Yes	No	Severe or rapid weight loss	Yes	No
Neurological disorders	Yes	No	Sexually transmitted disease	Yes	No
If yes, please specify _____			Excessive urination	Yes	No

Premedication

Has a physician or previous dentist recommended that you take antibiotic 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 _____

Sleep Questionnaire

1.	Do you feel well- rested when you wake up in the morning?	Yes	No
2.	Have you been told you snore?	Yes	No
3.	Have you been diagnosed with Sleep Apnea?	Yes	No
4.	Do you wear a C-Pap or have you in the past?	Yes	No
5.	Have you had a sleep study or been told to get a sleep study?	Yes	No

_____

Signature of patient/Legal Guardian