

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
- 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 Diseases 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
- 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