

MEDICAL HISTORY

Patient Name _____

Date of Birth _____ Age _____ Weight _____ Height _____

EMERGENCY INFORMATION

Physician _____ Telephone _____

Relative Name _____ Relationship _____

Address _____ Telephone _____

Circle

1. Are you having pain or discomfort at this time? YES NO
2. Have you ever had a bad experience in the dentistry office? What? YES NO
3. Have you been a patient in the hospital during the past two years? For what? YES NO

4. Have you been under the care of a medical doctor during the past two years? For what? YES NO

5. Have you taken any medicine or drugs during the past two years? What? YES NO

6. Have you ever taken any bisphosphonate medication (Boniva, Aredia, Zometa, Fosamax, Actonel, Didronel, Skelid) for osteoporosis, bone disease, or cancer? YES NO

7. Have you taken Viagra, Levitra, or Cialis in the past 48 hours? YES NO

8. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? If so, what YES NO

9. Have you ever had any excessive bleeding requiring special treatment? YES NO

10. Please circle YES or NO to the following:

| | | | | | | | | | | | |
|--------------------------|-----|----|--------------------|-----|----|--------------------------|-----|----|-------------------------|-----|----|
| Heart Failure | YES | NO | Stroke | YES | NO | Chemotherapy | | | Blood Transfusion | YES | NO |
| Heart Disease or | YES | NO | Kidney Trouble | YES | NO | (Cancer, Leukemia) | YES | NO | Drug Addiction | YES | NO |
| Attach (Chest Pains) | | | Ulcers | YES | NO | Arthritis | YES | NO | Hemophilia | YES | NO |
| High Blood Pressure | YES | NO | Emphysema | YES | NO | Rheumatism | YES | NO | Venereal Disease | YES | NO |
| Heart Murmur | YES | NO | Cough | YES | NO | Cortisone Medicine | YES | NO | (Syphilis, Gonorrhea) | YES | NO |
| Rheumatic Fever | YES | NO | Tuberculosis | YES | NO | Glaucoma | YES | NO | Cold Sores | YES | NO |
| Congenital Heart Lesions | YES | NO | Asthma | YES | NO | Pain in Jaw Joints | YES | NO | Genital Herpes | YES | NO |
| Scarlet Fever | YES | NO | Hay Fever | YES | NO | AIDS | YES | NO | Epilepsy or Seizures | YES | NO |
| Artificial Heart Valve | YES | NO | Sinus Trouble | YES | NO | AIDS Related Complex | YES | NO | Fainting or DizzySpells | YES | NO |
| Heart Pacemaker | YES | NO | Allergies or Hives | YES | NO | HIV Positive | YES | NO | Nervousness | YES | NO |
| Heart Surgery | YES | NO | Diabetes | YES | NO | Hepatitis A (infectious) | YES | NO | Psychiatric treatment | YES | NO |
| Artificial Joint | YES | NO | Alcoholism | YES | NO | Hepatitis B (serum) | YES | NO | Sickle Cell Disease | YES | NO |
| Mitral Valve Prolapse | YES | NO | Thyroid Disease | YES | NO | Liver Disease | YES | NO | Bruise Easily | YES | NO |
| Anemia | YES | NO | Radiation or | YES | NO | Chronic Bronchitis | YES | NO | Allergic to Sulfa | YES | NO |
| | | | Chronic Bronchitis | YES | NO | Yellow Jaundice | YES | NO | eggs | YES | NO |
| | | | | | | | | | latex | YES | NO |
| | | | | | | | | | soy beans | YES | NO |

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest. or shortness of breath, or because you are very tired? YES NO
12. Do your ankles swell during the day? YES NO
13. Do you use more than 2 pillows to sleep? YES NO
14. Have you lost or gained more than 10 pounds in the past year? YES NO
15. Do you ever wake up from sleep short of breath? YES NO
16. Are you on a special diet? YES NO
17. Do you take diet pills (i.e. Phen Fen)? YES NO
18. Has your medical doctor ever said you have a cancer or tumor? YES NO
19. Do you have any disease, condition, or problem not listed? YES NO
20. WOMEN: Are you pregnant now? YES NO
 - Is there a possibility you are pregnant? YES NO
 - Are you nursing? YES NO
 - Are you taking any oral contraceptives YES NO
21. Are you wearing contact lenses? YES NO
22. Do you smoke? How much? YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date _____ Signature of Patient, Parent or Guardian _____

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

| Date | BP | Pulse | Resp. | NPO | 6 hrs |
|-------|-------|-------|-------|-----|-------|
| _____ | _____ | _____ | _____ | YES | NO |
| _____ | _____ | _____ | _____ | YES | NO |
| _____ | _____ | _____ | _____ | YES | NO |
| _____ | _____ | _____ | _____ | YES | NO |
| _____ | _____ | _____ | _____ | YES | NO |
| _____ | _____ | _____ | _____ | YES | NO |