Medical History

NAME:_____Birthdate:_____

Mother (If Minor)_____Father (If Minor)_____

Physician's Name:_____Number:_____
Cardiologist's Name: _____ Number:_____
Emergency Contact Name: _____Number:_____

Please indicate with a check mark – if you have, or have had, any of the following:

_____Heart Problems
_____Mitral Valve Prolapse*****
_____Heart Murmur*****
_____Pacemaker*****
_____Defibrillator*, Active Implanted Medical Device*
_____Prosthetic Cardiac Valve*****
_____History of Bacterial Endocarditis*****
_____Congenital Heart Disease*****
_____Rheumatic Fever*****
_____Stroke
_____Angina
_____Congestive Heart Failure
_____Heart Attack*
_____Heart Surgery*
_____Pulmonary Shunts/Conduits*****
_____Stents*
_____Artificial Heart Valves*****
_____A Cardiac Transplant*****
_____High Cholesterol
_____High Blood Pressure
_____Circulatory Problems
_____Excessive Bleeding
_____Anemia
_____Hepatitis
Type _____
Status _____
_____Smoker
_____Cancer-Type_____
_____Family History Mouth/Throat Cancer
_____Radiation Treatments
_____Chemo/IV Bisphosphonate
_____Kidney Problems
_____Liver Problems
_____Blood Transfusion, If Yes, When _____
_____Current Invitro Treatment*

_____Diabetes: 1 / 2/Gestational/Family History
_____Endocrine Disease, i.e. Thyroid
_____Prosthetic replacements, i.e. Joints*
_____Pins*, Screws*, Plates*
_____Venereal Disease
_____Cold Sores
_____Substance Abuse
_____Psychiatric Care
_____HIV/AIDS
_____Tuberculosis Status _____
_____Asthma
_____History of Pneumonia
_____Sinus Problems
_____Eating Disorder
_____Previous use of Fen-Phen; Redux/Dexfenfluramine, Pondimin or Fenflurameine*
_____Arthritis: Osteoarthritis/Rheumatoid Arthritis
_____Osteoporosis
_____Oral Bisphosphonate Treatment
_____Paget's Disease
_____Epilepsy/Convulsions
_____Gastrointestinal Disease
_____Eye Disease i.e. Glaucoma
_____Hearing Impaired
_____Allergies to Novocaine
_____Allergies to Latex*
_____Allergies to Medicines or Drugs
_____Allergies to _____
_____Spina Bifida *
_____Pregnant (Currently)
_____Menopause
_____Birth Control Pills
_____Other – Explain_____
_____Dental Implants

_____History of Oral Surgery/Orthodontics/Gum-Periodontal Surgery/Hospitalizations/Surgeries
Circle & Explain the above _____
Do You Have City Water _____ Well Water _____ Fluoride in Your Water _____

Reported Symptoms of:
_____Bleeding Gums
_____Dry Mouth
_____Burning Mouth
_____Unexplained Weight Gain
_____Unexplained Weight Loss
_____a lump or thickening in the mouth
_____ear pain
_____hoarseness
_____swelling which effects the fit of a denture
_____red, white or discolored lesions in the mouth or on the lips
_____ Problem or Complication with Previous Dental Treatment

____Excessive Hunger/Thirst/Frequent Urination
____Sour Taste especially in the morning
____Heart Burn
____Belching
____Frequent Canker Sores
____soreness/difficulty in chewing or swallowing
____difficulty moving the jaw or tongue
____numbness of the tongue or mouth
____repeated bleeding from the mouth or throat

If you answered YES to any of these (*) questions, please call the office before your appointment.

Please list all medications including over the counter medications, herbs or vitamins. Please list the name, dosage and use:

Name of Medication	**Dosage/Frequency**	**Use**

Please describe any current medical treatment, operations, or any other medical or dental information that may possibly affect your dental treatment. I understand that it is my responsibility to notify this office of any change in my medical history prior to treatment.

Signature:_____ Date: _____

UPDATES: