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
Initial Blood Pressure _____________
Pulse _________________________
Temperature ___________________
______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
_____Last A1C ____________%
_____Endocrine Disease, i.e. Thyroid
_____Prosthetic replacements, i.e. Joints*
_____Pins*, Screws*, Plates*
_____Cold Sores
_____Substance Abuse
_____Psychiatric Care
_____HIV/AIDS
_____Tuberculosis Status _____________________
_____Asthma
_____History of Pneumonia
_____Sinus Problems
_____Eating Disorder
_____Covid-19 Present diagnosis – Date ____________
_____Covid-19 Previous Diagnosis & recovered - Date ____________________________
_____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 _______________________________
_____Pregnant (Currently)
_____Menopause
_____Birth Control Pills
_____Dental Implants
_____Other _ Explain _____________________________

_____History of Oral Surgery/Orthodontics/Gum-Periodontal Surgery/Hospitalizations/Surgeries
Circle & Explain the above ____
<u>Do You Have</u> City Water _________ Well Water _________ Fluoride in Your Water _______________

Reported Symptoms of:
- _______Bleeding Gums
- _______Dry Mouth
- _______Burning Mouth
- _______Unexplained Weight Loss/Gain
- _______ Excessive Hunger/Thirst/Frequent Urination
- _______Sour taste/heartburn/frequent belching
- _______Frequent Canker Sores
- _______Swollen lymph nodes/painful nodes
- _______Lump in mouth/throat/red/white/colored lesion in mouth
- _______Hoarseness/change in voice
- ____Difficulty swallowing/chewing/sensation of something caught in throat
- ____Numbness of tongue/mouth
- ____Unexplained ear pain
- ____Previous complications with dental treatment

_______ Cough

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.

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Signature:____ Date: ___________________________

UPDATES: