Medical History Form FAMILY DENTAL

Name _____Date_____

Date of Birth_____Height_____ Weight_____

Name of Primary Care Physician_____ Phone number_____

Please respond to the following questions regarding your medical health.

1) Date of last physical examination_____

2) Are you being treated for any medical condition?

_____

_____

3) Have you had a serious illness, operation or been hospitalized in the last 5 years?

_____

4) Please list all prescription and non-prescription medications that you are taking:

_____

_____

_____

_____

5) Are you allergic to or had a reaction to any of the following:

Local anesthetics	Yes ____	No____
Penicillin or other antibiotics	Yes ____	No____
Sulpha drugs	Yes ____	No____
Sedatives	Yes ____	No____
Aspirin	Yes ____	No____
Codeine or other narcotics	Yes ____	No____
Iodine	Yes ____	No____
Other _____		

Do you have any other allergies? _____

6) Do you have any of the following conditions:

a.	Diabetes	Yes____	No____
b.	Insulin treated Diabetes	Yes____	No____
c.	High blood pressure	Yes____	No____
d.	Low blood pressure	Yes____	No____
e.	Cardiovascular disease	Yes____	No____
f.	Damaged heart valves/Rheumatic Heart Disease	Yes____	No____
g.	Heart Murmur	Yes____	No____
h.	Stroke	Yes____	No____
i.	Shortness of Breath	Yes____	No____
j.	Swollen ankles	Yes____	No____
k.	Inborn heart defects	Yes____	No____
l.	Cardiac pacemaker/Defibrillator	Yes____	No____
m.	Heart attack	Yes____	No____
n.	Angina/Chest Pain	Yes____	No____
o.	Asthma	Yes____	No____
p.	Fainting Spells	Yes____	No____
q.	Seizures/Epilepsy	Yes____	No____
r.	Hepatitis/Liver Disease	Yes____	No____
s.	AIDS or HIV infection	Yes____	No____
t.	Thyroid disease or problems	Yes____	No____
u.	Empysema/Bronchitis/COPD	Yes____	No____
v.	Arthritis or painful joints	Yes____	No____
w.	Stomach Ulcer/Reflux/Acidity	Yes____	No____
x.	Crohn's or Colitis	Yes____	No____
y.	Kidney Disease	Yes____	No____
z.	Persistent Swollen Glands	Yes____	No____
aa.	Mental Health Issues/Psychiatric Care	Yes____	No____

bb.	Anxiety Disorder/Panic Attacks	Yes____	No____
cc.	Attention Deficit Disorder	Yes____	No____
dd.	Depression	Yes____	No____
ee.	Cancer/Radiation treatment	Yes____	No____
ff.	Abnormal Bleeding	Yes____	No____
gg.	Treatment of a tumor or growth	Yes____	No____
hh.	Osteoporosis/Bisphosphonate medicine	Yes____	No____

7) Do you smoke or use smokeless tobacco Yes____ No____
a) Are you a former tobacco user Yes____ No____
b) How many years have/did you used tobacco? _____
c) How much tobacco do/did you use per day? _____

8) Do you use/drink alcoholic beverages Yes____ No____
a) What type_____
b) How many times per week do you use alcoholic beverages?_____

9) Do you use illicit street drugs? Yes____ No____
a) What type_____

10) Do you wear contact lenses? Yes____ No____

11) Do you have pain/sounds in your TMJs? Yes____ No____

Women

11) Are you pregnant? Yes____ No____
12) Are you nursing? Yes____ No____
13) Are you taking birth control pills? Yes____ No____

I certify that I have rad and understand the above questionnaire. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not withhold information regarding my medical health. I will not hold my surgeon/physician or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of the Patient_____

Signature of Guardian/Parent _____ Relationship_____

To be completed by Surgeon

Medical Management Issues from questionnaire or oral interview

_____
_____

Date_____ Signature of Surgeon_____