Website Patient Medical History

Please answer all questions. Answers to the following questions are for our records only and will be considered confidential.

Are you in good health? Yes ○ No ○

Height _____ Weight _____

Has there been any change in your general health? Yes ○ No ○

Your last physical examination was on _____

Are you now under the care of a physician? Yes ○ No ○

Name and address of your physician _____

_____

Have you ever had a serious illness or operation? Yes ○ No ○

Have you been hospitalized with any of the following within the last 5 years?

- Did you have a persistent cough or cough up blood? Yes ○ No ○
- Low/High blood pressure(circle one) Yes ○ No ○
- Venereal Disease Yes ○ No ○
- AIDS or HIV+ Yes ○ No ○
- Other _____

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes ○ No ○

- Do you bruise easily? Yes ○ No ○
- Have you ever required a blood transfusion Yes ○ No ○
  If yes, explain the circumstances _____

Do you have any blood disorder such as anemia? Yes ○ No ○

Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips? Yes ○ No ○

Medications

Are you taking any drug or medication?

If yes, what? _____

Are you taking any of the following?

- Antibiotics or sulfa drugs Yes ○ No ○
- Anticoagulants (blood thinners such as Coumadin, Plavix etc) Yes ○ No ○
- Medicine for high blood pressure Yes ○ No ○
- Cortisone (steroids) Yes ○ No ○
- Tranquilizers Yes ○ No ○

- Aspirin Yes ○ No ○
- Insulin, Tolbutamide (Orinase) or similar drug Yes ○ No ○
- Digitalis or drugs for heart trouble Yes ○ No ○
- Nitroglycerin Yes ○ No ○
- Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramine), and Redux (dexfenfluramine) Yes ○ No ○
- Oral Contraceptives Yes ○ No ○
  If yes, what are you using?
- Chemotherapy Drugs Yes ○ No ○
- Osteoporosis Drugs (Fosamax, Aredia, Zometa etc.) Yes ○ No ○
- Any natural product, herbal supplement or homeopathic remedy? Yes ○ No ○
- Other

Habits

Do you smoke? Yes ○ No ○

If yes, how much?

Do you drink alcoholic beverages? Yes ○ No ○

Do you take any recreational drugs? Yes ○ No ○

Do you have any of the following?

Cardiac pacemaker Yes ○ No ○

Implants/Artificial prosthesis (Knee joints, elbow pins etc) Yes ○ No ○

A removable dental appliance Yes ○ No ○

Do you have, or have you had, any of the following diseases or problems?

- o Rheumatic fever or rheumatic heart disease Yes ○ No ○
- o Heart Murmur or mitral valve prolapse Yes ○ No ○
- o Congenital heart lesions Yes ○ No ○
- o Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes ○ No ○
  - ▪ Do you have pain in the chest upon exertion? Yes ○ No ○
  - ▪ Are you ever short of breath after mild exercise? Yes ○ No ○
  - ▪ Do you get short of breath when you lie down or do you require extra pillows when you sleep? Yes ○ No ○
- o Hepatitis, jaundice, or liver disease Yes ○ No ○
- o Convulsions/epilepsy Yes ○ No ○
- o Stroke Yes ○ No ○
- o Asthma or hay fever Yes ○ No ○
- o Hives or skin rash Yes ○ No ○
- o Fainting spells or seizures Yes ○ No ○
- o Diabetes Yes ○ No ○
  - ▪ Do you have to urinate (pass water) more than six (6) times a day? Yes ○ No ○

- Are you thirsty much of the time? Yes ○ No ○
- Does your mouth frequently become dry? Yes ○ No ○

- Arthritis Yes ○ No ○
- Inflammatory rheumatism (painful, swollen joints) Yes ○ No ○
- Stomach ulcers Yes ○ No ○
- Kidney trouble Yes ○ No ○
- Tuberculosis Yes ○ No ○
- Are you immunosuppressed? Possibly from transplant surgery Yes ○ No ○
- A tumor or growth Yes ○ No ○
- Radiation therapy or chemotherapy Yes ○ No ○
- Thyroid trouble Yes ○ No ○
- Bleeding tendency /abnormal bleeding Yes ○ No ○

ALLERGY

Are you allergic or have you reacted adversely to:

- Local anesthetic Yes ○ No ○
- Penicillin or other antibiotics (such as amoxicillin, clindamycin, erythromycin, Keflex etc) Yes ○ No ○
- Barbiturates, sedatives, or sleeping pills Yes ○ No ○
- Sulfa Drugs Yes ○ No ○
- Codeine Yes ○ No ○
- Valium or other tranquilizer Yes ○ No ○
- Aspirin Yes ○ No ○
- Iodine Yes ○ No ○
- Latex Yes ○ No ○
- Other

Have you had any serious trouble associated with previous dental treatment?

If yes, explain

For Women Only

Are you pregnant or could you be?

If yes, when are you due?

Are you nursing? Yes ○ No ○

Are you taking oral contraceptives? Yes ○ No ○

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my surgeon before my next visit.

Patient/Guardian Signature

Doctor Signature

Print Submit Reset