

PATIENT CONFIDENTIAL MEDICAL HISTORY

Patient's Name _____ **Account #** _____ **Date of Birth** _____

ALTHOUGH DENTAL PERSONNEL TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIPS WITH THE DENTISTRY THAT YOU WILL BE RECEIVING.

Thank you for answering the following questions:

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| <p>1. Are you in good healthYes / No</p> <p>2. Have there been any changes in your general health in the last yearYes / No</p> <p>3. Date of your last physical exam _____</p> <p>4. Physician's Name _____</p> <p>5. Are you under the care of a physician Yes / No</p> <p>6. Have you ever been hospitalized for any Surgical operation or serious illness Yes / No
If Yes, please explain _____</p> <p>7. Do you bruise easily Yes / No</p> <p>8. Have you had any abnormal bleeding .. Yes / No</p> <p>9. Are you taking any medicine (s) Yes / No including non-prescription medicine Yes/ No
If Yes, what medicine are you taking _____</p> | <p>10. Have you ever required a blood transfusion..... Yes / No</p> <p>11. Have you had a recent weight lossYes / No</p> <p>12. Do you use tobacco Yes / No</p> <p>13. Do you or have you used controlled substances Yes / No</p> <p>14. Are you wearing contact lensesYes /No</p> <p>15. Do you have a persistent cough or throat clearing..... Yes / No</p> <p>16. Do you have any disease, condition, or problem not listed above that you think the dentist should know about Yes / No</p> <p>WOMEN ONLY:</p> <p style="padding-left: 40px;">Are you pregnant or think you may be Yes / No</p> <p style="padding-left: 40px;">Are you nursing Yes / No</p> <p style="padding-left: 40px;">Are you taking birth control pills Yes / no</p> |
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Do you have or have you ever had the following:

<p>Heart disease, if yes please explain Yes / No</p> <p>Heart trouble Yes / No</p> <p>Heart Attack Yes / No</p> <p>Angina Yes / No</p> <p>Artificial Heart Valve Yes / No</p> <p>Heart Surgery Yes / No</p> <p>Congenital Heart Problem Yes / No</p> <p>Stents Yes / No</p> <p>Mitral Valve Prolapse Yes / No</p> <p>Heart Murmur Yes / No</p> <p>Rheumatic Heart Disease Yes / No</p> <p>Pacemaker Yes / No</p> <p>Stroke Yes / No</p> <p>Aids, HIV Infection Yes / No</p> <p>Hepatitis A Yes / No</p> <p>Hepatitis B Yes / No</p> <p>Hepatitis C Yes / No</p> <p>Liver Disease Yes / No</p> <p>Artificial Joints (Hip, Knee, etc.) Yes / No</p> <p>Swelling of Feet, Ankles, Hands Yes / No</p> <p>Cancer (Chemotherapy, Leukemia) Yes / No</p> <p>Glaucoma Yes / No</p> <p>Tuberculosis Yes / No</p> <p>Chest Pain Yes / No</p> <p>Blood Thinners (Cumadin or Aspirin) Yes / No</p> <p>Sexually Transmitted Disease Yes / No</p> <p>Herpes Yes / No</p>	<p>Rheumatic Fever Yes / No</p> <p>Scarlet Fever Yes / No</p> <p>Asthma Yes / No</p> <p>Shortness of Breath Yes / No</p> <p>Lung or Breathing Problems Yes / No</p> <p>COPD Yes / No</p> <p>Sinus Trouble Yes / No</p> <p>Persistent Cough Yes / No</p> <p>Cough that produces blood Yes / No</p> <p>Epilepsy or Seizures Yes / No</p> <p>Anemia Yes / No</p> <p>Diabetes Yes / No</p> <p>Eating Disorders Yes / No</p> <p>Hypoglycemia Yes / No</p> <p>Thyroid Problems Yes / No</p> <p>Stomach Ulcer Yes / No</p> <p>Kidney Trouble Yes / No</p> <p>Tumors Yes / No</p> <p>Mental Health Care Yes / No</p> <p>Back Problems Yes / No</p> <p>Cold Sores/Fever Blisters Yes / No</p> <p>Hives or Skin Rash Yes / No</p> <p>Fainting or Dizzy Spells Yes / No</p> <p>Chemical Dependency Yes / No</p> <p>High Blood Pressure Yes / No</p> <p>Low Blood Pressure Yes / No</p>
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Are you allergic to or have you had reactions to:

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| <p>Latex or rubber Yes / No</p> <p>Allergies to antibiotics _____ Yes / No</p> <p>Local Anesthetics like novocaine Yes / No</p> <p>Aspirin Yes / No</p> | <p>Any other allergies, please list: _____</p> <p>_____</p> <p>_____</p> |
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