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:

1. Are you in good health ……..Yes / No
2. Have there been any changes in your general health in the last year …….Yes / No
3. Date of your last physical exam _____
4. Physician's Name _____
5. Are you under the care of a physician Yes / No
6. Have you ever been hospitalized for any Surgical operation or serious illness ….. Yes / No
   If Yes, please explain _____
7. Do you bruise easily ……. Yes / No
8. Have you had any abnormal bleeding .. Yes / No
9. Are you taking any medicine (s) ….. Yes / No including non-prescription medicine ….. Yes/ No
   If Yes, what medicine are you taking _____
   _____
10. Have you ever required a blood transfusion…… Yes / No
11. Have you had a recent weight loss ……Yes / No
12. Do you use tobacco ……. Yes / No
13. Do you or have you used controlled substances …… Yes / No
14. Are you wearing contact lenses ……Yes /No
15. Do you have a persistent cough or throat clearing….. Yes / No
16. Do you have any disease, condition, or problem not listed above that you think the dentist should know about ……. Yes / No

WOMEN ONLY:

Are you pregnant or think you may be ….. Yes / No
Are you nursing …… Yes / No
Are you taking birth control pills …… Yes / no

Do you have or have you ever had the following:

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

Are you allergic to or have you had reactions to:

Latex or rubber	Yes / No
Allergies to antibiotics _____	Yes / No
Local Anesthetics like novocaine	Yes / No
Aspirin	Yes / No

Any other allergies, please list:_____
_____
_____