Nikodem DENTAL

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

Any other allergies, please list_________________________________
____

Do you have or have you ever had the following:

Heart trouble	Yes / No
Heart Attack	Yes / No
Angina	Yes / No
Artificial Heart Valve	Yes / No
Heart Surgery	Yes / No
Congenital Heart Problem	Yes / No
Stents	Yes / No
Mitral Valve Prolapse	Yes / No
Heart Murmur	Yes / No
Rheumatic Heart Disease	Yes / No
Pacemaker	Yes / No
Stroke	Yes / No
Aids, HIV Infection	Yes / No
Hepatitis A	Yes / No
Hepatitis B	Yes / No
Hepatitis C	Yes / No
Liver Disease	Yes / No
Artificial Joints (Hip, Knee, etc.)	Yes / No
Swelling of Feet, Ankles, Hands	Yes / No
Cancer (Chemotherapy, Leukemia)	Yes / No
Glaucoma	Yes / No
Tuberculosis	Yes / No
Chest Pain	Yes / No
Blood Thinners (Coumadin or Aspirin)	Yes / No
Sexually Transmitted Disease	Yes / No
Herpes	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 Novocain	Yes / No
Aspirin	Yes / No

Heart disease, if yes please explain Yes / No

Rheumatic Fever	Yes / No
Scarlet Fever	Yes / No
Asthma	Yes / No
Shortness of Breath	Yes / No
Lung or Breathing Problems	Yes / No
COPD	Yes / No
Sinus Trouble	Yes / No
Persistent Cough	Yes / No
Cough that produces blood	Yes / No
Epilepsy or Seizures	Yes / No
Anemia	Yes / No
Diabetes	Yes / No
Eating Disorders	Yes / No
Hypoglycemia	Yes / No
Thyroid Problems	Yes / No
Stomach Ulcer	Yes / No
Kidney Trouble	Yes / No
Tumors	Yes / No
Mental Health Care	Yes / No
Back Problems	Yes / No
Cold Sores/Fever Blisters	Yes / No
Hives or Skin Rash	Yes / No
Fainting or Dizzy Spells	Yes / No
Chemical Dependency	Yes / No
High Blood Pressure	Yes / No
Low Blood Pressure	Yes / No

Do you now or have you ever taken Bisphosphonates for bone loss? Yes / No

Are you required to take Pre-Medication for any reason? Yes / No Explain_________________