

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?

○ Rheumatic fever or rheumatic heart disease	Yes	No
○ Heart Murmur or mitral valve prolapse	Yes	No
○ Congenital heart lesions	Yes	No
○ 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
○ Hepatitis, jaundice, or liver disease	Yes	No
○ Convulsions/epilepsy	Yes	No
○ Stroke	Yes	No
○ Asthma or hay fever	Yes	No
○ Hives or skin rash	Yes	No
○ Fainting spells or seizures	Yes	No
○ 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