

Medical History

Name: _____

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| <p>Have you ever had any of the following illnesses? Please check all that apply.</p> <p>Heart attack <input type="checkbox"/></p> <p>Heart failure <input type="checkbox"/></p> <p>Angina <input type="checkbox"/></p> <p>Coronary Artery Disease <input type="checkbox"/></p> <p>Arrhythmia <input type="checkbox"/></p> <p>High Blood Pressure <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/></p> <p>Emphysema/ COPD <input type="checkbox"/></p> <p>Other lung disease <input type="checkbox"/></p> <p>Diabetes <input type="checkbox"/></p> <p>Kidney disease <input type="checkbox"/></p> <p>Rheumatic fever <input type="checkbox"/></p> <p>Ulcers <input type="checkbox"/></p> <p>Epilepsy/ seizures <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/></p> <p>Liver disease <input type="checkbox"/></p> <p>HIV / AIDS <input type="checkbox"/></p> <p>Prosthetic Joint(s) <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/></p> <p>Thyroid disease <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/></p> <p>Hepatitis <input type="checkbox"/></p> <p>Circle: A B C D</p> <p>Height: _____' _____"</p> <p>Weight: _____Lbs.</p> | <p>Please complete all items. Leave no blanks.</p> <p>List dates and reasons for all prior hospitalizations. _____ or None <input type="checkbox"/></p> <p>_____</p> <p>_____</p> <p>List and provide dates for all prior surgeries. _____ or None <input type="checkbox"/></p> <p>_____</p> <p>_____</p> <p>Do you take any medicines regularly? (If so please list. Include herbal, alternative, and non-prescription medications.) _____ or None <input type="checkbox"/></p> <p>_____</p> <p>_____</p> <p style="text-align: right;">Yes No</p> <p>Have you been under the care of a physician in the last 5 years? <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you allergic to any medications or foods? (Ex: Penicillin, codeine, sulfa, aspirin, Novocaine, latex, eggs, soy) <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you taking, or have you ever taken, medication for osteoporosis, myeloma, breast cancer, or other bone disease? (Ex: Fosamax, Actonel, Boniva, Didronel, Aredia, Zometa, Reclast) <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever been diagnosed with a heart murmur? If yes, have you been instructed to take antibiotics prior to dental procedures? <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you smoke, or use chewing tobacco? <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes how much? _____</p> | <p style="text-align: right;">Yes No</p> <p>Have you ever tested positive for HIV, Hepatitis, Tuberculosis, or other infectious disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you tend to bleed or bruise easily, or have a family history of bleeding disorders? <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you suffer from chronic sinus or nasal problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever had a bad reaction to anesthesia, or do you have a family history of anesthesia problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever been diagnosed with jaw joint (TMJ) problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>Do your jaw joints (TMJ) pop, click, or get stuck? <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you had anything to eat or drink in the last 8 hours? <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use marijuana, cocaine, methamphetamine, heroin, or other "recreational" or "street" drugs? <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you have any other disease, condition or problem not listed, or do you wish to speak with the doctor privately about anything? <input type="checkbox"/> <input type="checkbox"/></p> <p>Female Patients:</p> <p>Are you pregnant or suspect you may be pregnant? <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how many weeks? _____</p> <p>Date of last menstrual period: _____</p> <p>Are you taking birth control pills? <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you aware that antibiotics may interfere with birth control pills? <input type="checkbox"/> <input type="checkbox"/></p> |
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To the best of my knowledge, all of the above is true and correct. I understand that a complete and accurate medical history is important for my own safety when undergoing any surgical procedure.

Signature _____
 (Patient, Parent/Guardian if minor)

Date _____

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