

HEALTH & MEDICAL HISTORY

CONFIDENTIAL

2018 - 2019

To ensure your well being while undergoing therapy in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

Your Name Your date of birth

Your primary care physician's name and address

Your primary care physician's telephone number Your preferred pharmacy and telephone number.

OFFICE USE ONLY

Pre-Medicate No Yes Comments:

Do you now or have you had any of the following problems?

Cardiovascular Disease. No Yes Check all that apply:

- heart disease, heart attack, heart palpitations, stroke, or brain attack, angina, congestive heart failure, hardening of the arteries, coronary bypass, heart murmur, mitral valve prolapse, high blood pressure, low blood pressure

- Rheumatic fever or rheumatic heart disease? Yes No
Have you ever seen your heart on a TV? Yes No
Congenital heart defects? Yes No
Prosthetic (artificial) heart valves? Yes No
Heart pacemaker or defibrillator? Yes No
Aneurysm? Yes No
Coronary angioplasty? Yes No
High cholesterol? Yes No
Are you short of breath after one flight of stairs? Yes No
Do your ankles swell? Yes No
Do you get short of breath when you lie down? Yes No
Do you have chest pain upon exertion? Yes No
Abnormal bleeding or extended clotting time? Yes No
Been advised to take antibiotic before dental work? Yes No
Frequent or unexpected nose bleeds? Yes No
Frequent bleeding gums? Yes No

Diabetes? No Yes

If yes, do you require insulin? Type & Dose No Yes
Are you insulin resistant? No Yes

- Family history of Diabetes?
mother, mother's mother, mother's father, father, father's mother, father's father

Do you have an artificial joint? No Yes
If yes, which joint(s)?

Hepatitis? If yes, check type: No Yes

- Type A, Type B, Type C, Other, Non-Specific Type, Don't know

Have you had a Hepatitis C test? No Yes

Have you ever required a blood transfusion? No Yes

If yes, what was the date of the transfusion?

Are you HIV positive? No Yes

Do you have any reason to suspect that you have been exposed to the HIV virus? No Yes

Have you ever had Tuberculosis (TB)? No Yes

Do you have a cough that lasted more than 3 weeks? No Yes

Do you ever cough up blood? No Yes

Have you ever had a TB test? Yes No

Did you ever have a TB test, test positive? No Yes

PLEASE CHECK ANY THAT APPLY:

- Anemia, Hemophilia/Bleed Easily, Leukemia, Sickle Cell Anemia, Blood Disorder, Vision Problems, Glaucoma, Earaches; Ringing in Ears, Hearing Loss, Meniere Disease, Sinus Problems, Seasonal Allergies, Breathing Difficulties, Asthma, Chronic Bronchitis, Emphysema, Eating Disorder, Missing Teeth, Gastroesophageal Reflux, Chronic Mouth Dryness, On special diet, Frequent Sore Throat, Stomach/Intestinal Ulcers, Colitis, Persistent Diarrhea, Yellow Jaundice, Liver Disease, Cirrhosis of the Liver, Thyroid Problems, Urinate Frequently, Kidney/Bladder Problems, Dialysis, Injury to Neck or Face, Severe Headaches, Fainting or Dizzy Spells, Seizures or Convulsions, Psychological Therapy, Depression, Panic attacks, Phobias, Alzheimer's Disease, Parkinson's Disease, Insomnia, Muscle aches, cramps, Neuralgia, Muscular dystrophy, Joint Replacement, Osteoarthritis, Rheumatoid Arthritis, Osteoporosis, Multiple Sclerosis, Autoimmune Disease, Systemic Lupus, Immune System Disorder, Tumor or Cancer, Chemotherapy, Radiation Treatment, Organ Transplant, Enlarged Lymph Nodes, Night Sweats, Substance Abuse Therapy, Sexually Transmitted Disease, Herpes, Skin Problems, Mouth or Teeth, Sleep apnea

Describe serious illness or surgery or conditions not listed above:

Table with 2 columns: When, Description

Are you seeing a physician now for the treatment of a recent or ongoing medical condition? No Yes If yes, please explain (feel free to continue writing on last page):

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Have you had a serious illness, operation or been hospitalized in the last year? No [] Yes [] If yes, please explain:

Have you ever had any serious medical trouble associated with any dental experience? No [] Yes [] If yes, please explain:

Do you consider yourself currently under an abnormally high amount of stress? No [] Yes []

Have you had any unexplained or unplanned weight loss recently? No [] Yes []

When was your last complete physical exam with your medical doctor including blood tests? _____ EKG? Yes [] No []

Do you now or have you ever smoked? No [] Yes []

(Please circle) Cigarettes Pipe Cigar Other

If you currently smoke, how much? _____

If you have smoked in the past but no longer smoke, when did you quit? _____

Do you chew tobacco? No [] Yes [] If yes, how often?

Do you drink alcohol? No [] Yes [] If yes, how much?

If you use tobacco, how interested are you in stopping?

(Please circle one) Very Somewhat Not Interested

Are you pregnant now? No [] Yes [] Due Date: _____

Is there any possibility you might be pregnant? Yes [] No []

Do you anticipate becoming pregnant? Yes [] No []

Do you have regular gynecological checkups? Yes [] No []

Have you reached menopause? Yes [] No []

Are you currently on hormone replacement therapy? Yes [] No []

Family history of oral cancer or skin cancer? Yes [] No []

[] mother [] mother's mother [] mother's father

[] father [] father's mother [] father's father

[] brothers [] sisters

Do you "sunbathe" or use a tanning bed? Yes [] No []

Quality of Sleep - How likely are you to doze off or fall asleep in the following situations?

Table with 5 columns: No Chance of dozing, Slight chance of dozing, Moderate chance of dozing, High chance of dozing. Rows include activities like sitting and reading, watching TV, sitting in public places, etc.

During Sleep (as experienced by you and witnessed by others)

Table with 3 columns: Often, Sometimes, Never. Rows include snoring, stop breathing, choke or struggle for breath, etc.

Have you ever had an overnight sleep study? Yes [] No [] Results: _____

Sports

Do you play team sports on a regular basis? Yes [] No []

If yes, which one(s)? _____

Do you have an athletic mouth guard that fits well? Yes [] No []

Family history of tooth loss or full dentures? Yes [] No []

[] mother [] mother's mother [] mother's father

[] father [] father's mother [] father's father

[] brothers [] sisters [] spouse, or significant other

If you are currently taking these medications, check the box on the left. If you have taken any of these medications within the past year, but are not taking them currently, check the box on the right.

Table with 2 columns: Now, Past Year. Lists various medications like antibiotics, antidepressants, antihistamines, etc.

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Please list all medications & supplements you are currently taking.

Do your gums bleed, either when chewing, brushing, flossing or at any other time? no yes

Does your mouth feel dry during the day or at night? no yes

Are you ALLERGIC to any of the following medications (do you get hives, a rash, have trouble breathing, etc.):

- Antibiotics (penicillin, tetracycline, etc.) Yes No
- Local dental anesthetics (lidocaine, etc.) Yes No
- Codeine or other narcotics Yes No
- Aspirin Yes No
- Iodine Yes No
- Barbiturates, sedatives or sleeping Yes No
- Tranquilizers Yes No
- Sulfa drugs Yes No
- Latex Yes No
- Plastics Yes No
- Foods (peanut, soy, etc.) _____ Yes No
- Metals (specify) _____ Yes No
- Others (specify) _____ Yes No

Have you ever had an adverse reaction such as nausea, dizziness, or feeling "spacey" with any drugs or medication? Yes No

Do you have any disease, condition or problems not previously listed that you feel we should know about? Yes No

Your Home Care Routine:

How often do you **floss** your teeth? _____ times a day week

How often do you **brush** your teeth?
_____ x day AM PM after meals Other

How long do you normally brush?
 30 seconds more than 1 minute more than 2 minutes

Type of toothbrush _____

Type of paste _____

Other oral hygiene aids _____

How often do you use? _____

Do you ever have a problem with bad breath? no yes

Do your gums ever feel irritated, tender or swollen? no yes

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change. I will inform the **Doctor of Dental Surgery (DDS)** at the next appointment.*

Patient / Parent / Guardian _____ Date _____

BP _____ / _____ T _____ P _____ R _____

ASA Physical Status I II III IV