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
- ❒ father
- ❒ mother's mother
- ❒ father's mother
- ❒ mother's father
- ❒ 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 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:

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?

☐ Check one in each row:	No Chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	❒	❒	❒	❒
Watching TV	❒	❒	❒	❒
Sitting inactive in a public place (i.e. a theater, waiting room)	❒	❒	❒	❒
As a passenger in a car for an hour without a break	❒	❒	❒	❒
Lying down to rest in afternoon	❒	❒	❒	❒
Sitting and talking to someone	❒	❒	❒	❒
Sitting quietly after lunch without alcohol	❒	❒	❒	❒
In auto while stopped for a few minutes in traffic	❒	❒	❒	❒

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

	Often	Sometimes	Never
Snore loudly	❒	❒	❒
Stop breathing	❒	❒	❒
Choke or struggle for breath	❒	❒	❒
Toss and turn frequently	❒	❒	❒
Grind your teeth	❒	❒	❒
Awaken during the night	❒	❒	❒
Awaken with a headache	❒	❒	❒
Have had morning fatigue, fogginess, or Awakened feeling un-refreshed	❒	❒	❒

Average hours of sleep per night?
4 5 6 7 8 9 10 11 12 +

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.

Now	Past Year	
❒	❒	Antibiotics/Sulfa Drugs
❒	❒	Antidepressants (Prozac, Zoloft, Lexipro, etc.)
❒	❒	Antihistamines
❒	❒	Anticoagulants
❒	❒	Blood Pressure Medicine
❒	❒	Blood Thinners
❒	❒	Codeine
❒	❒	Steroids, Cortisone, Prednisone, etc.
❒	❒	Cholesterol Medication
❒	❒	Decongestants
❒	❒	Diet Medication, i.e. "phen-fen", Meridia, etc.
❒	❒	Digestive Aids
❒	❒	Heart Medication
❒	❒	Hormones (birth control pills, estrogen replacement)
❒	❒	Inhalants
❒	❒	Insulin
❒	❒	Muscle Relaxants
❒	❒	Nitroglycerine
❒	❒	Pain Medicine (Aspirin, Advil, Tylenol, etc.)
❒	❒	Prescription Pain Medication (Celebrex, etc.)
❒	❒	Sleeping Pills
❒	❒	Thyroid Medicine
❒	❒	Tranquilizers
❒	❒	Vitamins
❒	❒	Others _____
❒	❒	Others _____
❒	❒	Others _____

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Please list all medications & supplements you are currently taking.

_____

_____

_____

_____

_____

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 ❒

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 ❒

Please feel free to expand upon anything else you feel is relevant or any questions from the previous pages either here, or on the back of this page.

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 ***D****octor of* ***D****ental* ***S****urgery (****DDS****) at the next appointment.*

_____

Patient / Parent / Guardian Date

BP _____/_____ T_____ P_____ R_____

ASA Physical Status I II III IV