MEDICAL HISTORY FORM ENG

PATIENT'S NAME: _____ **DOB**_____

Mark **Yes** or **No**

Do you have or have you had any of the following?:

Yes No -Artificial heart valve(s) / Stents
Yes No -Previous infective endocarditis
Yes No -Damaged heart valves
Yes No -Congenitally heart defect (CDH)
Yes No -Knee, joint, or hip replacement ****Date:**_____
Yes No -Chest pain upon exercise or angina
Yes No -Heart murmur
Yes No -Heart attack / Stroke
Yes No -Pacemaker
Yes No -Rheumatic fever / Rheumatic heart disease
Yes No -Cancer / Chemotherapy / Radiotherapy
Yes No -Tuberculosis
Yes No -Asthma
Yes No -Bronchitis / Emphysema / Sinus trouble
Yes No -High / Low blood pressure
Yes No -Kidney disease / Dialysis
Yes No -Hepatitis or other liver disease
Yes No -Diabetes I / II
Yes No -Sexual transmitted disease
Yes No -Epilepsy / Seizures / Fainting spells
Yes No -Emotional / Mental disorders
Yes No -AIDS or HIV positive
Yes No -Migraine or frequent headaches
Yes No -Blood transfusion ****Date:**_____
Yes No -Anemia / Other blood disorders
Yes No -Abnormal bleeding after surgery or trauma
Yes No -Thyroid problems
Yes No -Arthritis
Yes No -Fibromyalgia / Chronic pain syndrome
Yes No -G.E. Reflux / Persistent heartburn
Yes No -Eating disorder
Yes No -Sleep disorder

Do you smoke or use chewing tobacco? ❑YES ❑NO
If Yes, how many a day?_____ For how long?_____

History of alcohol or drug abuse? ❑YES ❑NO
If yes, for how long? _____ Have you been rehabilated? _____

Any family History of disease of the heart, kidney, liver, immune system, neurologic, high BP, stroke, cancer, diabetes. ❑YES ❑NO

Are you allergic to any of the following?

Yes No -Latex materials
Yes No -Penicillin
Yes No -Other antibiotics. Which one?_____
Yes No -Local anesthetics ("Novocain")
Yes No -Codeine or other narcotics
Yes No -Sulfa drugs
Yes No -Barbiturates, sedatives, or sleeping pills
Yes No -Aspirin
Yes No -Other:_____

During the past 12 months or at the present time, have you taken any of the following?

Yes No -Aspirin
Yes No -Anticoagulants (Plavix, Coumadin, etc)
Yes No -Antibiotics or Sulfa drugs
Yes No -High blood pressure medicine
Yes No -Antidepressants or Tranquilizers
Yes No -Insulin, Orinase, or other diabetes drugs
Yes No -Digitalis (e.g, Digoxin) for Cardiovascular disease
Yes No -Nitroglycerin
Yes No -Cortisone or other steroids
Yes No -Osteoporosis Medicine (bisphosphonates-e.g, Fosamax)
Yes No -Nonprescription drug/supplements
Yes No -Other. **List:** _____

Have you taken in the past five years any of the following?

Yes No -Cortisone or other steroids
Yes No -Osteoporosis Medicine (bisphosphonates-e.g, Fosamax)

HEIGHT_____ **WEIGHT**_____

ONLY FOR WOMEN:

Yes No -Are you pregnant?. Weeks?: _____
Yes No -Are you nursing?
Yes No -Taking hormones or contraceptives?

❑YES ❑NO Do you think you're a healthy person with a Good General Condition?
❑YES ❑NO Have you been hospitalized or had surgery in the past three years?. Why? _____
❑YES ❑NO Do you have other condition/s not listed above that we should know? Which?: _____
❑YES ❑NO Do you have a regular physician? Provide his/her Name:_____ Ph #:_____

I certify that I have read and understand the above and the information given on this form is accurate. I understand the importance of a truthful heath history and that the dentist and his/her staff will rely on this information for treating my child or me. I acknowledge that my questions about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors of omissions that I may have made in the completion of this form. I understand that I am fully responsible to communicate any changes regarding the medical condition of my child or mine during future dental visits.

_____ _____ _____
PATIENT'S SIGNATURE / GUARDIAN of Minor **Relationship with patient** **DATE**

For completion by the dentist.

ASA PS Classification: _____ **Medical Consult Needed?:** ❑YES ❑NO **BP**: _____ **Pulse**: _____

Comments: _____

DENTIST'S SIGNATURE _____