MEDICAL HISTORY

Please answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health?.....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?.....Y N
5. The name, address and phone number of my physician Is:_____
   _____
   _____
6. Please list all previous surgeries, hospitalizations and/or serious illness? .....Y N
   _____
   _____
   _____
   _____
   _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   A. Prosthetic (Artificial) Heart Valve, Infective Endocarditis (HeartValve Infection) or Congenital Heart Disease?.....Y N
   B. Cardiovascular Disease (Heart Attack, Heart Failure, Rheumatic Fever/Rheumatic Heart Disease, Heart Murmur/Damaged Heart Valves, Coronary Artery Disease/Angina/Chest Pain, High Blood Pressure, Stroke, Palpitations/Irregular Heart Beat, Pacemaker, Heart Surgery?).....Y N
   C. Lung Disease (Asthma, Emphysema, Chronic Cough/Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Severe Coughing, Bloody Sputum)? .....Y N
   D. Seizures/ Epilepsy, Fainting/Dizziness, Anxiety/Depression? .....Y N
   E. Bleeding Disorder, Anemia, Sickle Cell Trait/Disease, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .....Y N
   F. Liver Disease (Jaundice, Hepatitis)?.....Y N
   G. Kidney Disease? .....Y N
   H. Diabetes? .....Y N
   I. Thyroid Disease? .....Y N
   J. Arthritis? .....Y N
   K. Stomach Ulcers, Hiatal Hernia/Reflux Disease? .....Y N
   L. Glaucoma? .....Y N
   M. Osteoporosis? .....Y N
   N. Implants/Artificial Joints placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   O. Chemotherapy or Radiation (X-ray) treatment for Cancer?.....Y N
   P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .....Y N
   Q. Significant Sinus/Nasal or Allergy problems?.....Y N
   R. Any disease, drug or transplant operation that has depressed your immune system?.....Y N
   S. Snoring/Sleep Apnea? .....Y N
8. **ARE YOU CURRENTLY USING ANY OF THE FOLLOWING:**
   A. Antibiotics? .....Y N
   B. Anticoagulants (Blood Thinners)? .....Y N
   C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   D. High Blood Pressure medications? .....Y N
   E. Steroids (Cortisone, etc.)?.....Y N
   F. Tranquilizers/Antidepressants? .....Y N
   G. Insulin or Oral Anti-Diabetic drugs?.....Y N
   H. Oral Contraceptives?.....Y N
   I. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   J. Inhaler/Nebulizer? .....Y N
   K. Are you taking or ***have you ever taken*** Bisphosphonates for Osteoporosis, Multiple Myeloma or other cancers (i.e., Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa or Denosumab/Prolia)? ..Y N
   L. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____
      _____
      _____
      _____
      _____
      _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION (i.e., SWELLING, RASH, ITCHING, SHORTNESS OF BREATH, etc.) TO:**
   A. Local Anesthetics (Novocain, etc.)?.....Y N
   B. Penicillin or other antibiotics?.....Y N
   C. Sulfa Drugs?.....Y N
   D. Sedatives, Barbiturates? .....Y N
   E. Aspirin or Ibuprofen?.....Y N
   F. Codeine or other pain killers?.....Y N
   G. Latex/Rubber Products or Tape? .....Y N
   H. Soybeans or Eggs?.....Y N
   I. Iodine?.....Y N
   J. Other allergies or reactions? Please, list.....Y N
      _____
      _____
      _____
      _____
      _____
10. Do you smoke or chew Tobacco? .....Y N
    How much per day? _____How many years?_____
11. Do you drink Alcohol?.....Y N
    How much per day? _____How many years?_____
12. Do you use or have you ever used Street/Recreational Drugs? .....Y N
13. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .....Y N
14. Have you had any serious problems associated with any previous dental treatment? .....Y N
15. Have you or an immediate family member ever had any significant problem associated with Intravenous/General anesthesia (i.e., High Fever, Delayed Awakening/ Prolonged Recovery, Allergic Reaction, Malignant Hyperthermia, etc)?.....Y N
16. Are you wearing Contact Lenses?.....Y N
17. Are you undergoing Pain Management/Treatment for Chronic Pain with Narcotics or other Medications?.....Y N
18. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
19. Do you wish to talk to the doctor privately about anything?.....Y N
20. **FOR WOMEN ONLY:** Date of Last Period:_____
    A. Are you Pregnant, or **is there any chance** you might be Pregnant? .....Y N
    B. Are you Breast-Feeding? .....Y N
    C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

MEDICAL HISTORY

I understand the importance of a truthful Medical History to assist the doctor in providing the best care possible.

Date	***Signature of Person Completing Medical History***	Doctor's Initials

FUNCTIONAL CAPACITY: **BMI:**

FOR COMPLETION BY THE DOCTOR

Comments/Significant Findings from Patient Interview/Medical History Form:

Management Considerations:

Date: Doctor's Initials: