

Name : _____

MEDICAL HISTORY

Are you presently being treated for any medical condition? If yes, please explain _____

Are you presently under the care of a physician ? If yes, please explain _____

Have you had a medical examination in the last year ? For ? _____

When was your last complete physical? _____ New findings? _____

Has there been any change in your general health in the past year? If yes, please explain _____

Have you ever been tested positive for any immunocompromising disease? If yes, please explain _____

Is there any other medical condition, adverse reaction, disease or problem not listed above? If yes, please explain _____

Have you ever been hospitalized for any serious illness, operations, or conditions requiring extensive medical care? _____

Have you ever been advised by your doctor(s) to take antibiotics before dental treatment? _____

Do you have or have you ever had any of the following ? (If yes, please circle)

<p><u>Heart</u></p> <ul style="list-style-type: none">- Heart condition/problem- heart murmur- heart disease- heart surgery/valve surgery- prosthetic heart valve- heart attack- heart arrhythmia- angina pectoris- low blood pressure- high blood pressure- rheumatic fever- mitral valve prolapse- pacemaker- congenital heart lesion- chest pains on exertion- shortness of breath on exertion- fluttering in chest- pounding feeling in chest- extra pillows to sleep or recline <p><u>Infectious Diseases</u></p> <ul style="list-style-type: none">- Measles- Mumps- Rubella- Chicken Pox- AIDS- HIV + <p><u>Digestive System</u></p> <ul style="list-style-type: none">- stomach ulcer- Stomach disorder- Gastric reflux- Heartburn- Colitis- Intestinal problem- intestinal ulcer- gall bladder problem- special diet- lost 10 lbs. in last year- gained 10 lbs. in last year <p><u>Allergies, Adverse Reactions or Hypersensitivities</u></p> <ul style="list-style-type: none">- Penicillin- Aspirin- Codeine- Local or general anesthetic- Sulpha- Sleeping Pills- OTHER drugs/medicine/injections _____- latex/rubber _____- Environmental allergies _____- metal allergies (ie jewelry) _____- Hay Fever- Eczema- Foods _____- Hives, Rashes _____	<p><u>Circulatory System</u></p> <ul style="list-style-type: none">- bleeding problem/disorder- excessive bleeding- Anemia- Sickle Cell Anemia- Hemophilia- Leukemia- AIDS- HIV +- Sexually Transmitted Disease- Diabetes- hyperglycemia- hypoglycemia- Gout- bruise easily- take aspirin- Malignant Hypothermia- blood transfusion- warned against giving blood- give blood regularly- swelling (hands/ankles/feet) <p><u>Neuro/Muscular/Skeletal</u></p> <ul style="list-style-type: none">- Multiple Sclerosis- Muscular Dystrophy- Nervous Disorder- Psychiatric Care- Arthritis- Rheumatism- Prosthetic/Artificial joints- Osteoporosis <p><u>Cancer</u></p> <ul style="list-style-type: none">- radiation therapy- chemotherapy- cancer- malignant growth- tumors <p><u>Eating Disorders</u></p> <ul style="list-style-type: none">- bulimia- anorexia nervosa	<p><u>Brain</u></p> <ul style="list-style-type: none">- Stroke- brain attack- epilepsy- seizures- dizzy spells- fainting spells- faint easily- psychiatric disorder- psychiatric treatment <p><u>Liver and Kidney</u></p> <ul style="list-style-type: none">- liver disease- Hepatitis A/B/C- Jaundice- kidney disease- bladder infection- bladder problems <p><u>Lungs/Respiratory</u></p> <ul style="list-style-type: none">- shortness of breath- lung disease- Emphysema- Tuberculosis- Asthma- Pneumonia- Bronchitis- persistent cough <p><u>Operations/Surgery</u></p> <ul style="list-style-type: none">- heart transplant- organ transplant- joint replacement (hip/knee)- Tonsillectomy- other operations requiring hospitalization _____ <p><u>Women Only</u></p> <ul style="list-style-type: none">- trying to get pregnant- pregnant, due date? _____- breast feeding- Birth Control Pill- Hormone Replacement Therapy- Hysterectomy <p><u>Taking the Following Medications</u></p> <ul style="list-style-type: none">- Steroids/Cortisone- Birth Control Pill- Aspirin, Coumadin, Heparin- Diet pill therapy- Hormone Replacement Therapy- other prescription drugs _____- other over-the-counter (non-prescription) drugs _____- Herbal Supplements _____- OTHER _____	<p><u>Eyes</u></p> <ul style="list-style-type: none">- Glaucoma- contact lens wearer- eye problems <p><u>Ears</u></p> <ul style="list-style-type: none">- frequent ear aches- hearing difficulties- ear infections <p><u>Mouth</u></p> <ul style="list-style-type: none">- cold sores- Strep Throat- throat infections <p><u>Face/Jaw/Teeth</u></p> <ul style="list-style-type: none">- serious injury- surgery- radiation therapy <p><u>Head and Neck</u></p> <ul style="list-style-type: none">- frequent headaches- migraines- tonsillar problems- Thyroid Disease- sinus trouble- post nasal drip- jaw joint pain <p><u>Family History of...</u></p> <ul style="list-style-type: none">- diabetes- cancer- heart disease- other _____ <p><u>Social History</u></p> <ul style="list-style-type: none">- drug addiction/dependency- alcohol dependency- smoker- chew tobacco <p><u>Dental History</u></p> <ul style="list-style-type: none">- nervous during dental treatment
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