MEDICAL HISTORY FORM

Name: ____ Date: _______________

Date of Birth: _________ Sex: M / F Height: __________ Weight: _____________

Why are you here today? ______________________were you given any antibiotics or pain medicine for this appointment **CHECK ONE**_ *YES or NO*

Do you have or have you had the following diseases or problems? **(CHECK all that apply and then explain)**

Heart Disease: Heart Attack, Chest Pain, Coronary Artery Disease, Heart Surgery, Pacemaker, Defect at Birth, Valve Replacement, Irregular Heart Beat, Congestive Heart Failure, History of Bacterial Endocarditis, Other

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Breathing Problems: Asthma, Bronchitis, COPD, Emphysema, Sleep Apnea, Shortness of Breath, Tuberculosis, Other

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Vascular: High Blood Pressure, Low Blood Pressure, Stroke, TIA, Hardening of the Arteries, Other

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Endocrine: Diabetes (Insulin Dependent or Non-Insulin Dependent), Hypoglycemia, Thyroid problems, Other

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Neurologic: Anxiety, Dementia, Epilepsy, Fainting Spells, Headaches, Seizures, Mentally Handicapped, Other

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Liver/Kidney Disease: Hepatitis, Jaundice, Dialysis, Kidney Failure, Kidney Stones, Other

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Musculoskeletal: Arthritis, Artificial Joint, Fibromyalgia, MS, Osteoporosis, Other

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Gastrointestinal: Ulcers, GERD, Colitis, Crohn's Disease, Gastric Bypass, Other

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Head and Neck: Chronic Sinusitis, Swollen Glands, Difficulty Swallowing, Glaucoma, Radiation Therapy, TMJ Disorder

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Hematologic: Anemia, Bleeding Disorder, Blood Transfusions, Hemophilia, Leukemia, Lymphoma, Other

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Cancer: Breast, Prostate, Lung, Mouth, Colon, Skin, Uterine, Other Cancer, Chemotherapy, Radiation

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Immune System: HIV, AIDS, Immunosuppressive Drug Therapy (Remicade, Enbrel, Humira), Other

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Females: Pregnant, Breast Feeding, other ____

***Are you to take a "PREMED" antibiotic prior to dental treatment by a medical provider (ex: cardiologist, Orthopedist)? CHECK ONE** *YES or NO*

If yes, which antibiotic?_________________________ For what medical condition?_____________________________

***Have you taken the following Bisphosphonate Drugs?** Fosamax, Actonel, Boniva, Reclast, **Zometa, Aredia**

***Do you use tobacco products? CHECK ONE** *YES or NO* **If yes, what products and how often?** ___________________

***Alcohol use: CHECK ONE** ____ None ____Social or Occasional ____Daily

***Do you have a history of Drug Abuse? CHECK ONE** *YES or NO* **Please explain:** ______________________________

***Are you currently under a Pain Management Contract? CHECK ONE** *YES or NO*

If yes, please list your doctor: ____

***Please list ALL previous SURGERIES you have had with SEDATION (ex: colonoscopy) and dates:**

____

____

____

***Did you or any family members have complications following previous surgeries? CHECK ONE** *YES or NO*

Please explain: ____

***Did you have Nausea or Vomiting following previous surgeries? CHECK ONE** *YES or NO*

***Are you allergic to any of the following? (Please check all that apply)**

__ Amoxicillin	__ Eggs	__ Sulfa Medicines
__ Anesthetics	__ Latex	__ Sulfites
__ Aspirin	__Penicillin	__Soy
__Codeine	__ Narcotic	__Other ______________________________

***Please list all current MEDICATIONS, HERBAL and/or VITAMINS that you are taking:**

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____

Patient (Guardian) Signature:______________________________ Relationship: _____________ Date:_______________

Doctor Signature: ____ Date: _______________________________________