Crystal Springs DENTAL

MEDICAL HISTORY

DATE:

PATIENT NAME: _____ _____ _____ _____
LAST FIRST MI PREFERRED NAME

BIRTHDATE:

PHYSICAN'S NAME & PHONE NUMBER:

DATE OF LAST PHYSICAL:

1. Do you consider yourself in good health?
☐ Yes ☐ No

2. Has there been any change in your general health within the past year?
☐ Yes ☐ No

3. Are you under the care of a physician?
☐ Yes ☐ No

If yes, what condition is being treated?

4. Have you ever had a serious illness or operation?
☐ Yes ☐ No

If yes, what was the illness or problem?

5. Do you have or have you ever had any of the following conditions? Please check all that apply.

☐ Abnormal bleeding	☐ AIDS/HIV infection	☐ Angina
☐ Anemia	☐ Arthritis	☐ Asthma
☐ Autoimmune disease	☐ Cancer	☐ Cardiovascular disease
☐ Chemotherapy/Radiation	☐ Congestive heart failure	☐ Diabetes – type I or II
☐ Dizziness/fainting spells	☐ Eating disorder	☐ Emphysema
☐ Epilepsy	☐ Glaucoma	☐ Heart attack
☐ Heart murmur	☐ Hepatitis A, B or C	☐ High blood pressure
☐ Low blood pressure	☐ HPV/STD	☐ Kidney problems
☐ Mitral valve prolapsed	☐ Neurological disorders	☐ Osteoporosis
☐ Pacemaker	☐ Persistent heartburn	☐ Prosthetic joints
☐ Recurrent infections	☐ Rheumatic fever	☐ Headaches/migraines
☐ Sinus trouble	☐ Thyroid problems	☐ Sleep disorders (sleep apnea)
☐ Stomach ulcers	☐ Stroke	☐ Tuberculosis
☐ Substance abuse (drug or alcohol)		

Additional notes:

6. Allergies- Are you allergic to or have you had you had a reaction to:

☐ Local anesthetics	☐ Aspirin	☐ Penicillin
☐ Other antibiotics	☐ Sedatives	☐ Sulfa drugs
☐ Codeine or other narcotics	☐ Iodine	☐ Strawberries
☐ Kiwi fruit	☐ Latex	☐ Animals
☐ Food	☐ Other	

Additional notes:

7. Joint replacement. Have you had an orthopedic total joint (hip, knee) or heart valve replaced?

☐ Yes ☐ No

8. Have you ever been given antibiotic prior to dental treatment?

☐ Yes ☐ No

If yes, what was the reason?

9. Have you ever or are you taking medications for osteoporosis such as Fosamax or Actonel?

☐ Yes ☐ No

10. Have you had or are you being treated for:

☐ Multiple Myeloma ☐ Metastatic Cancer ☐ Pagets Disease ☐ Osteoporosis

If you checked any of the above, were you or are you being treated with bisphosphonates (such as Boniva or Fosamax)?

☐ Yes ☐ No

11. Have you ever had surgery or radiation treatment for tumor, growth or other conditions?

☐ Yes ☐ No

12. Do you use tobacco products?

☐ Yes ☐ No

If you use tobacco products, what type of tobacco product?

☐ Cigarettes ☐ Cigars ☐ Chewing tobacco

If you smoke cigarettes, how many do you smoke a day?

How interested are you in stopping? ☐ Very ☐ Somewhat ☐ Not interested

13. Please list the drugs, medications and vitamins that you are currently taking:

14. Do you have any condition or health problems not mentioned previously?

☐ Yes ☐ No

If yes, please explain:

15. WOMEN ONLY. Are you:

Taking birth control or hormone replacement?

☐ Yes ☐ No

Pregnant?

☐ Yes ☐ No

If yes, how many weeks and due date. _____

Nursing?

☐ Yes ☐ No

Signature _____ Date _____