□ **PRE-MED**
□ **IN DENTRIX**

□ **Allergies**

MEDICAL HISTORY

Name____ Home Phone (___)________________
Last First MI **Cell Phone** (___)________________
Address ____ City ________________________
State _________ Zip Code_________________ **E-mail**____
Date of Birth ______/______/______ **Social Security#** ___________________________________
Place of Employment ________________________________ Work Phone (___)________________
Sex □ M / □ F Height __________ Weight__________ **REFERRED BY**________________________
□ Single / □ Married / □ Widowed Name of Spouse ____
Emergency Contact Name________________________________ Phone (___)______________________
Name of medical physician_________________________________ Phone (____)___________________

Please circle yes or no to the following health questions. Your answers are for our records only and are confidential. Your initial visit may include additional follow-up questions concerning your health.

1. Are you in good health?. . . . . YES. . . . . NO
2. Have there been any changes in your general health within the past year?. . . . YES. . . . . NO
3. My last physical exam was ___________________________
4. Are you under the care of a physician for a specific condition?. . . . . YES. . . . . NO
   If yes, what is the condition being treated? ____________________________________
6. Have you had any serious illness, operation or been
   hospitalized in the past 5 years?. . . . . .YES. . . . . NO
   If yes, what was the illness or problem? ______________________________________
7. Are you taking any medicine(s) including non-prescription medicine?. . . . . . .YES. . . . . NO
   If yes, please list:____

   ____

   (attach list if necessary)
8. Have you ever smoked or used other tobacco products? . . . . YES. . . . . NO
   Are you a current smoker or user of tobacco products?. . . . . YES. . . . . NO
9. Have you ever been treated for Osteoporosis, Osteopenia, Metastatic
   Cancer, Multiple Myeloma, Breast Cancer and/or Paget's Disease?. . . . . . YES. . . . . NO
   a. If yes, are you **now** or have you **ever** taken orally, by injection
   or intravenously a Bisphosphonate drug such as Fosamax,
   Boniva, Actonel or Reclast? ***(Please circle which drug)***. . . . . .YES. . . . . NO
10. Do you have or have you had any of the following? ***(Please circle condition)***
   A. Heart Murmur, Mitral Valve Prolapse (MVP), Inborn heart defect
   Cardiac Pacemaker, Damaged or artificial heart valves,
   Rheumatic Heart Disease? . . . . YES. . . . . NO
   B. Cardiovascular Disease, Heart Attack, Angina, Stroke
   Coronary Insufficiency, Coronary Occlusion, Arteriosclerosis?. . . . YES. . . . . NO
   1. Chest pain upon exertion? . . . . .YES. . . . . NO
   2. Shortness of breath after mild exercise/lying down?. . . . . .YES. . . . . NO
   3. Do your ankles swell?. . . . . .YES. . . . . NO
   C. Artificial joints (knee or hip replacement) ***(Please circle)***. . . . . YES. . . . . NO

*******PLEASE TURN OVER/CONTINUED ON OTHER SIDE*******

D. Allergies / sinus issues / hayfever. . . . . YES. . . . . NO
E. Arthritis or painful swollen joints. . . . . YES. . . . . NO
F. Asthma. . . . . YES. . . . . NO
G. Cancer . . . . YES. . . . . NO
H. Diabetes. . . . . YES. . . . . NO
I. Epilepsy or other neurological disease . . . . YES. . . . . NO
J. Fainting spells or seizures. . . . . YES. . . . . NO
K. Glaucoma. . . . . YES. . . . . NO
L. Hepatitis, jaundice or liver disease **(Please Circle)**. . . . . YES. . . . . NO
M. High Blood Pressure. . . . . YES. . . . . NO
N. HIV infection or AIDS. . . . . YES. . . . . NO
O. Kidney Disease. . . . . YES. . . . . NO
P. Low blood pressure . . . . YES. . . . . NO
Q. Mental health condition. . . . . YES. . . . . NO
R. Persistent diarrhea or unexplained weight loss. . . . . YES. . . . . NO
S. Persistent cough or cough that produces blood. . . . . YES. . . . . NO
T. Persistent swollen glands in neck. . . . . YES. . . . . NO
U. Respiratory problems such as emphysema . . . . YES. . . . . NO
V. Stomach ulcer or hyperacidity. . . . . YES. . . . . NO
W. Thyroid problem . . . . YES. . . . . NO
X. Tuberculosis. . . . . YES. . . . . NO
Y. Sexually transmitted disease (STD). . . . . YES. . . . . NO
Z. Suppressed immune system/organ transplant. . . . . YES. . . . . NO

11. Have you ever had abnormal bleeding or needed a blood transfusion? . . . . . . YES. . . . . NO
12. Do you have a blood disorder such as anemia?. . . . . YES. . . . . NO
13. Have you ever had treatment for a tumor or growth?. . . . . YES. . . . . NO
14. Have you had radiation treatment? If yes, anatomy location?_____________ YES. . . . . NO
15. **Are you allergic to or ever had an allergic reaction to**:
    Penicillin or other antibiotic (*please specify*)______________________ YES. . . . . NO
    Barbiturates, sedatives or sleeping pills . . . . YES. . . . . NO
    Aspirin. . . . . YES. . . . . NO
    Local anesthetic . . . . YES. . . . . NO
    Other ____
16. Have you had serious trouble with any previous dental treatment?. . . . . YES. . . . . NO
    If yes, please explain____
17. Do you have any other medical condition we should know about?. . . . . YES. . . . . NO
    If yes, please explain____
18. Are you wearing contact lenses? . . . . YES. . . . . NO
19. Are you wearing removable dental appliances? . . . . YES. . . . . NO

WOMEN ONLY

20. Are you pregnant?. . . . . YES. . . . . NO
21. Do you have any problems associated with your periods?. . . . . YES. . . . . NO
21. Are you nursing?. . . . . YES. . . . . NO
22. Are you taking birth control pills?. . . . . YES. . . . . NO

CHIEF DENTAL COMPLAINT____

I certify that I have read and understand this form. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my dentist or staff responsible for any omissions or errors I may have made in completing this form.

PATIENT/GUARDIAN SIGNATURE ____ Date ____________

If not patient, relationship to patient ____

*****PLEASE TURN OVER/CONTINUED ON OTHER SIDE*****