MEDICAL HISTORY

Patients Name: _____ *Office Use: If two patients with same name DOB:*

Please check any of the following that apply to you:

☐Anemia
☐Arthritis/Rheumatism
☐Artificial Heart/Valve
☐Artificial Joints
☐Asthma
☐Back Problems
☐ Blood Disease
☐ Blood Transfusion
☐ Bruise Easily
☐Cancer
☐Chemical Dependency
☐Chemotherapy
☐Circulatory Problems
☐Cortisone Treatments
☐Cough, Persistent
☐Cough up blood
☐Diabetes
☐Dizziness/Fainting
☐Drug Addiction
☐Emphysema
☐Epilepsy
☐Glaucoma
☐Headaches or Migraines
☐ Heart Conditions
☐ Heart Lesions (Congenital)
☐ Heart Murmur
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis A, B or C
☐ High Blood Pressure
☐ HIV/AIDS
☐Jaundice
☐Jaw/Joint Pain
☐Kidney Disease
☐ Liver Disease
☐Low Blood Pressure
☐ Mitral Valve Prolapse
☐Nervousness/Depression
☐Pacemaker
☐ Phen Fen (1 month +)
☐ Radiation (head/neck)
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Shortness of Breath
☐ Skin rash
☐Stomach Problems
☐Stroke
☐Swelling of feet or ankles
☐Thyroid Problems
☐ Tonsilitis
☐Tuberculosis
☐Ulcers
☐ Venereal Diseases
☐ Other:

Women Only:
☐Pregnant Currently
☐ Nursing
☐ Birth Control

Do you have any of the following allergies? Yes/No
☐Allergies (Seasonal)
☐Aspirin
☐Barbiturates (sleeping pills)
☐ Darvon
☐Nitrous Oxide
☐Percodan
☐Local Anesthetic
☐Codeine
☐Latex
☐Erythromycin
☐Valium
☐penicillin
☐Sulfa
☐Other

Are you under a physician's care? Explain what for?
Physician's Name:
_____

_____

List ALL medications you currently take (Rx & Over the counter) or attach list?
_____

_____

Please check any of the following drugs you have used at any time:

Yes or No			Yes or No			Yes or No			Yes or No	
☐	☐	Fosamax	☐	☐	Didronel	☐	☐	Zometa	☐	☐ Boniva
☐	☐	Aredia	☐	☐	Actonel	☐	☐	Skelid		

Is there any other medical or dental information we should know about? **Any surgeries or serious illness?**

_____

Using the Epworth Sleepiness Scale of 0-3 How likely are you to doze off or fall asleep in the following situations?

No chance of dozing = 0 Slight chance of dozing = 1 Moderate chance of dozing = 2 High chance of dozing = 3

__ Sitting and reading
__ Watching TV
__ Sitting in a public place, ie...theater or a meeting
__ As a passenger in a car for an hour without a break
__ Lying down to rest in the afternoon if conditions permit
__ Sitting and talking to someone
__ Sitting quietly after lunch without alcohol
__ In a car, while stopped for a few minutes in traffic

The above information is accurate and complete to the best of my knowledge . I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of the form.

Signature(Patient/Guardian/Parent) Date: Dentist Signature Date: