

M E D I C A L ♦ H I S T O R Y

Physician's Name _____ Phone _____

Have You Been Hospitalized in the Last Five (5) Years yes no

Please Explain: _____

Preferred Pharmacy _____ Phone _____

Pharmacy Location _____

DRUG ALLERGIES (Please check/circle all that apply)

- Antibiotics: Amoxicillin Clindamycin Cephalexin Erythromycin Penicillin Sulfa, other _____
- Pain Medications: Aspirin Codeine Darvocet Hydrocodone Oxycodone NSAIDS Tylenol, other _____
- Dental Local Anesthesia: enzocaine Epinephrine Lidocaine Septocaine Carbocaine Marcaine, other _____
- Sedatives: Halcion (Triazolam) Valium (Diazepam) Xanax (alprazolam) Ambien (Zolpidem), other _____
- Metals: Nickel Mercury Costume Jewelry Copper Gold Silver Amalgam, other _____
- Latex /RubberLatex gloves Rubber dam Elastic Band-aids Rubber cups (polishing).....other _____

Medical History

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Artificial/Prosthetic Heart Valve | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Paget's Disease |
| <input type="checkbox"/> Cardiac Transplant | <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Periodontal Disease |
| <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Congenital Heart Defect (CHD) | <input type="checkbox"/> Angina | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Heart Murmur w/ regurgitation | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pregnancy/Nursing |
| <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Pins, posts, hip replacement | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A-B-C | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Previous Infective Endocarditis | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Herpes Oral | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Prosthetic Joints | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Recent Heart Surgery last 6 mo | <input type="checkbox"/> Cancer | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Steroid or Cortisone Use |
| <input type="checkbox"/> Shunts | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Strong Gag Reflex |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Thyroid Disease | |
| Other disorder not listed:

_____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Transient Ischemic Attack |
| | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker Heart | <input type="checkbox"/> Tuberculosis |
| | | | <input type="checkbox"/> Ulcers |

Current prescription medications: _____

Current Herbal or Over the Counter Medications: _____

Have you ever taken medications for OSTEOPOROSIS? Yes No

If so, Which drug? Actonel Aredia Boniva Fosamax Zometa Other

Do you smoke, chew tobacco, or dip? _____ # of years? _____ How often? _____

Are you at risk for oral cancer? (Check all that apply)

- Alcohol Use White or Red Patches in Mouth Sun Exposure HPV virus Tobacco

Do you ever use any recreational drugs? Yes No Be specific: _____

For your protection: Some drugs may interfere with dental anesthetics, prescriptions, or sedatives, and their combinations can be dangerous if combined. All information provided is strictly confidential and will not be shared.

I certify that I have answered the questions on this health history accurately and completely.

Signature _____ Printed Name _____ Date _____