MEDICAL HISTORY

Your cooperation in providing accurate information is necessary for us to meet your dental needs in a manner that is compatible with your general health. Incorrect information can be dangerous to your health. *Any* ***change*** *in your* ***health status*** *should be reported to this office.* Thank you for your assistance, cooperation, and understanding.

Patient Name (If other than patient, include name of person completing this form) Relationship to patient

____

Have you been **hospitalized** in the last five years? ___YES ___NO If YES, Please list date(s) and condition(s) treated:

____

Are you now, or have you been under the care of a physician within the last two years? ___YES ___NO If SO, for what conditions?

____

Name of your Primary Physician:____ Telephone:___________________________

DO YOU NOW or HAVE YOU EVER had any **allergies to medications?** ___YES ___NO ___penicillin ___sulfa drugs ___codeine

Allergies to any **other medications**? (please list):____

Latex Sensitivity? ___YES ___NO Hay Fever? ___YES ___NO Any **other allergies**? ___YES ___NO

If SO, please list: ____

FOR THE FOLLOWING SECTIONS, please initial **_YES** or **_NO** for the **lead question (Do you have…?).**
If you answer "NO" to the lead question, you may skip to the next section.

1. CARDIOVASCULAR (HEART): Do you have any cardiovascular (heart) problems? **___YES ___NO, GO TO 2.**

___anuerysm
___angina (chest pains)
___bacterial endocarditis
___stroke when?__________
___cardiac arrythmia
___pacemaker
___congestive heart failure
___congenital heart disease
___dizziness or fainting
___heart attack when?_______
___heart murmur
___shortness of breath
___high blood pressure
___low blood pressure
___mitral valve prolapse
___open heart surgery
___rheumatic heart disease

BLOOD PRESSURE:
________/________

PULSE:____________

Please list all medications you are taking for this condition: ____
____

2. HEMATOLOGIC (BLOOD): Do you have any hematologic (blood) problems? **___YES ___NO, GO TO 3.**

___anemia ___abnormal/excessive bleeding ___hemophilia ___sickle cell anemia

Please list all medications you are taking for this condition: ____
____

3. INFECTIOUS DISEASES: Do you have any infectious diseases? **___YES ___NO, GO TO 4.**

___HIV/AIDS ___hepatitis (type________) ___herpes simplex virus ___tuberculosis

Please list all medications you are taking for this condition: ____
____

4. **ENDOCRINE (GLANDULAR): Do you have any endocrine (glandular) problems?** ___**YES** ___**NO, GO TO 5.**

___diabetes ___hyperthyroidism ___hypothyroidism ___high blood sugar
___low blood sugar ___goiter

Please list all medications you are taking for this condition: ____
____

5. **OTHER: Do you now or have you ever had any of the following conditions?** ___**YES** ___**NO, GO TO 6.**

___asthma ___liver problems ___ulcers ___colitis
___arthritis ___kidney disease/dialysis ___frequent heartburn/GERD ___rheumatic fever
___cancer ___organ transplant ___joint replacement ___lupus
when?_____type?________ when?_____type?________ when?_____type?________ ___epilepsy

Please list all medications you are taking for this condition: ____
____

6. **SOCIAL:** **Please initial all positive responses** **NO, All responses below are negative**______

___I consume more than two alcoholic beverages per day. ___I chew tobacco products.
___I smoke tobacco products.

WOMEN: **Please initial all positive responses** **NO, All responses below are negative**______

___Are you pregnant? ____trimester due date:_______________
___Are you nursing? ___Are you taking Birth Control Pills?

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS NOT COVERED IN THIS QUESTIONNAIRE? ___**YES** ___**NO**

If YES, please explain: ____
____

PLEASE LIST any medications including over the counter medicines and/or dietary supplements you are taking that you have not already listed on this questionnaire:

___I am not taking any other medications. I am taking the following medications in addition to what I have already listed:
____
____

I verify that the information I have given is true and accurate to the best of my knowledge. I will not hold Arbor Hills Dental Care, P.C., its employees, staff, or my dentist responsible for any errors or omissions I may have made in the completion of this form. I authorize my dentist to release, request, and discuss my medical conditions with my physicians. After discussion with me, I authorize my dentist and any of his/her staff which he/she deems fit to take x-rays, study models, photographs or any other procedures necessary to make a complete and thorough diagnosis of my dental conditions. In the case of an emergency, I also authorize my dentist and any of his/her staff which he/she deems fit to perform any forms of treatment and render any medications which may be medically necessary or indicated.

____
Signature of patient or legal guardian *Date*

FOR OFFICE USE ONLY

Medical & Dental History Reviewed by:____
Signature of Dentist *Date*