Dr. Tom Family & Cosmetic Dentistry

MEDICAL HISTORY

Patient Name: _____ **Birth Date:_____**

Preferred Name:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering all the following questions.

If you mark "Yes" to any of the following questions, please provide more information to the right of the question.		
Are you under a physician's care now? If so, please list their name and phone number.	❍ Yes ❍ No	
Have you ever been hospitalized or had a major operation?	❍ Yes ❍ No	
Are you taking any medications, pills, or drugs?	❍ Yes ❍ No	
Do you take, or have you taken, Phen-Fen or Redux?	❍ Yes ❍ No	
Have you ever taken Fosamax, Boniva, Reclast, Actonel or any other medications containing bisphosphonates?	❍ Yes ❍ No	
Are you on a special diet?	❍ Yes ❍ No	
Do you have a Neurologic Condition (Ex: Add/Depression/MS)	❍ Yes ❍ No	
Do you use tobacco?	❍ Yes ❍ No	

Are you allergic to any of the following?

❍ Aspirin	❍ Metal	❍ Acrylic	❍ Codeine
❍ Ibuprofen	❍ Latex	❍ Local Anesthetics	❍ Acetaminophen (Tylenol)
❍ Penicillin	❍ Sulfa Drugs		

If any other allergy, please list:_____

Women: Are you…

❍ Pregnant/Trying to get pregnant ❍ Nursing ❍ Taking oral contraceptives

-Please fill out back as well-

Do you have, or have you had, any of the following? If yes, please describe in the Additional Information Box.

HEART/HEMATOLOGY
- ❍ Anemia
- ❍ Angina, Chest Pains
- ❍ Artificial Heart Valve
- ❍ Blood Disease/Disorder
- ❍ Blood Transfusion
- ❍ Bruise Easily
- ❍ Congenital Heart Disorder
- ❍ Excessive Bleeding
- ❍ Fainting/Syncope/ Dizziness
- ❍ Heart Attack/Failure
- ❍ Heart Murmur
- ❍ Heart Pacemaker
- ❍ Heart Stent
- ❍ Heart Trouble/Disease
- ❍ Hemophilia
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Infective Endocarditis
- ❍ Irregular Heartbeat
- ❍ Low Blood Pressure
- ❍ Mitral Valve Prolapse
- ❍ Sickle Cell Disease
- ❍ Stroke
- ❍ Swelling of Limbs

RESPIRATORY
- ❍ Anaphylaxis
- ❍ Asthma
- ❍ Breathing Problem
- ❍ Emphysema
- ❍ Hay Fever
- ❍ Lung/ Respiratory Disease
- ❍ Sinus Trouble
- ❍ Sleep Disorder
- ❍ Snoring

ENDOCRINE
- ❍ Diabetes (List HbA1c: _____)
- ❍ Glaucoma
- ❍ Hormone Deficiency
- ❍ Hypoglycemia
- ❍ Kidney Problems
- ❍ Liver Disease/ Jaundice
- ❍ Parathyroid Disease
- ❍ Renal Dialysis
- ❍ Thyroid Disease

INFECTIONS
- ❍ AIDS/HIV
- ❍ Cold Sores/Fever Blisters
- ❍ Hepatitis (Specify Type in Comments)
- ❍ Herpes
- ❍ Hives/Rash
- ❍ Rheumatic/ Scarlet Fever
- ❍ Shingles
- ❍ STD
- ❍ Tonsillitis
- ❍ Tuberculosis

DIGESTIVE
- ❍ Digestive Disorders (Celiac/Gastric Reflux)
- ❍ Stomach/Intestinal Disease
- ❍ Ulcers
- ❍ Frequent Diarrhea
- ❍ Jaw Pain

ONCOLOGY
- ❍ Cancer/ Tumors/ Growths
- ❍ Chemotherapy/ Immunosuppression
- ❍ Radiation treatments
- ❍ Recent Weight Loss

MENTAL HEALTH
- ❍ Alzheimer's Disease
- ❍ Drug Addiction
- ❍ Epilepsy/ Seizures/ Convulsions
- ❍ Frequent Headaches
- ❍ Mental Handicap
- ❍ Psychiatric Care
- ❍ Anxiety (Dental or Other)

JOINTS
- ❍ Arthritis/Gout/Lupus
- ❍ Artificial Joint
- ❍ Cortisone Medicine
- ❍ Head or Neck Injury
- ❍ Osteoporosis/ Osteopenia
- ❍ Rheumatism

List any serious illness not mentioned on this page:

Comments and Additional Information:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____ **Date:**_____

Signature of Patient, Parent or Guardian