dillinghamhanson

Family, Cosmetic, & Implant Dentistry

MEDICAL HISTORY

Name:____ Date:______________________

Age:________________ Height:______________________ Weight:______________________

Name of physician:______________________________ Location:______________________

Date of most recent visit with physician:______________________ Reason:______________________

What is your estimate of your general health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

DO YOU HAVE OR HAVE YOU EVER HAD (mark "Yes" or "No")

CARDIOVASCULAR

- Congestive Heart Failure ◯ Yes ◯ No
- Heart Attack ◯ Yes ◯ No
- Angina Pectoris (Chest Pain) ◯ Yes ◯ No
- Arteriosclerosis ◯ Yes ◯ No
- High Blood Pressure ◯ Yes ◯ No
- Low Blood Pressure ◯ Yes ◯ No
- Heart Murmur ◯ Yes ◯ No
- Mitral Valve Prolapse ◯ Yes ◯ No
- Rheumatic or Scarlet Fever ◯ Yes ◯ No
- Congenital Heart Defect ◯ Yes ◯ No
- Artificial/Prosthetic Heart Valve ◯ Yes ◯ No
- Damaged Heart Valves ◯ Yes ◯ No
- Repaired Heart Defect ◯ Yes ◯ No
- Arrhythmias ◯ Yes ◯ No
- Heart Pacemaker ◯ Yes ◯ No
- Implantable Defibrillator ◯ Yes ◯ No
- Coronary Bypass ◯ Yes ◯ No
- Coronary Angioplasty ◯ Yes ◯ No
- Cardiac Stent ◯ Yes ◯ No
- Heart Transplant ◯ Yes ◯ No
- Aneurysm ◯ Yes ◯ No
- History of Infective Endocarditis ◯ Yes ◯ No
- High Cholesterol ◯ Yes ◯ No

HEMATOLOGIC

- Blood Transfusion ◯ Yes ◯ No
- Anemia ◯ Yes ◯ No
- Hemophilia ◯ Yes ◯ No
- Leukemia ◯ Yes ◯ No
- Sickle Cell Anemia ◯ Yes ◯ No
- Prolonged Bleeding ◯ Yes ◯ No
- Abnormal Bleeding ◯ Yes ◯ No
- Taking a Blood Thinner ◯ Yes ◯ No

NEUROLOGIC

- Vision Problems ◯ Yes ◯ No
- Glaucoma ◯ Yes ◯ No
- Earaches, Ringing in Ears ◯ Yes ◯ No
- Hearing Loss ◯ Yes ◯ No
- Fainting or Dizzy Spells ◯ Yes ◯ No
- Stroke ◯ Yes ◯ No
- Epilepsy, Seizures, Convulsions ◯ Yes ◯ No
- Psychiatric Treatment ◯ Yes ◯ No
- Panic Attacks ◯ Yes ◯ No
- Phobias ◯ Yes ◯ No
- Anxiety ◯ Yes ◯ No
- Depression ◯ Yes ◯ No
- ADD/ADHD ◯ Yes ◯ No

GASTROINTESTINAL

- Stomach/Intestinal Ulcers ◯ Yes ◯ No
- Colitis ◯ Yes ◯ No
- Persistent Diarrhea ◯ Yes ◯ No
- Hepatitis ◯ Yes ◯ No
- Liver Disease ◯ Yes ◯ No
- Yellow Jaundice ◯ Yes ◯ No
- Cirrhosis ◯ Yes ◯ No
- Eating Disorder ◯ Yes ◯ No
- Gastric Reflux (GERD) ◯ Yes ◯ No
- Frequent Heartburn ◯ Yes ◯ No

PULMONARY

- Allergies or Hives ◯ Yes ◯ No
- Asthma ◯ Yes ◯ No
- Chronic Cough ◯ Yes ◯ No
- Emphysema ◯ Yes ◯ No
- Tuberculosis (TB) ◯ Yes ◯ No
- Pneumonia ◯ Yes ◯ No
- Shortness of Breath ◯ Yes ◯ No
- Sarcoidosis ◯ Yes ◯ No
- Breathing Difficulties ◯ Yes ◯ No
- Sleep Apnea ◯ Yes ◯ No
- Snoring ◯ Yes ◯ No
- Frequent Sinus Infections ◯ Yes ◯ No

DERMAL/MUSCULOSKELETAL

- Allergy to Latex ◯ Yes ◯ No
- Skin Rash ◯ Yes ◯ No
- Night Sweats ◯ Yes ◯ No
- Osteoarthritis ◯ Yes ◯ No
- Rheumatoid Arthritis ◯ Yes ◯ No
- Systemic Lupus ◯ Yes ◯ No
- Other Autoimmune Disorder ◯ Yes ◯ No

- Artificial (Prosthetic) Joint ◯ Yes ◯ No
  - Date:______________________________
  - Any Complications ◯ Yes ◯ No

ENDOCRINE

- Diabetes ◯ Yes ◯ No
  HbA1c = _______________
- Thyroid or Parathyroid Disease ◯ Yes ◯ No
- Taking Cortisone/Other Steroid ◯ Yes ◯ No
- Hormone Deficiency ◯ Yes ◯ No

GENITOURINARY

- Urinate Frequently ◯ Yes ◯ No
- Kidney, Bladder Problem ◯ Yes ◯ No
- Dialysis ◯ Yes ◯ No
- Kidney Transplant ◯ Yes ◯ No
- Sexually Transmitted Disease ◯ Yes ◯ No
- HPV ◯ Yes ◯ No
- HIV/AIDS ◯ Yes ◯ No

OTHER CONDITIONS

- Frequent Sore Throats ◯ Yes ◯ No
- Persistent Swollen Lymph Node or Gland ◯ Yes ◯ No
- Use Tobacco (Smoking or Smokeless tobacco) ◯ Yes ◯ No
- If so, how interested are you in Quitting?◯ Very ◯ Somewhat ◯ Not Interested
- Use Alcohol ◯ Yes ◯ No
- Use Recreational Drugs ◯ Yes ◯ No
- Drug or Alcohol Addiction (Recovering or Current) ◯ Yes ◯ No
- Tumor or Cancer ◯ Yes ◯ No
- Radiation Therapy ◯ Yes ◯ No
- Chemotherapy ◯ Yes ◯ No
- Immunosupressive Medication ◯ Yes ◯ No
- Osteoporosis or Osteopenia (taking bisphosphonates) ◯ Yes ◯ No
- Paget's Disease ◯ Yes ◯ No
- Head or Neck Injuries ◯ Yes ◯ No
- Chronic Pain ◯ Yes ◯ No

- Sleep Disorder ◯ Yes ◯ No
- Frequent Headaches/Migraines ◯ Yes ◯ No
- Adverse Reaction to Local or General Anesthetic ◯ Yes ◯ No
- Other allergies ◯ Yes ◯ No
  If yes, list:____
  ____
  ____
- Any Disease, Problem, or Condition not Listed ◯ Yes ◯ No
  If yes, list:____
  ____
  ____

ARE YOU

- Presently Being Treated for any other Illness? ◯ Yes ◯ No
- Aware of a Change in your Health in the Last 24 hours? ◯ Yes ◯ No
- Taking Medications for Weight Management? ◯ Yes ◯ No
- Taking a Dietary Supplement? ◯ Yes ◯ No
- Often Exhausted of Fatigued? ◯ Yes ◯ No
- Have you been treated, or are you scheduled to begin treatment with IV bisphosphonate drugs for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? ◯ Yes ◯ No
  - Date treatment began:_______________

WOMEN ONLY

- Taking Birth Control Pills ◯ Yes ◯ No
- Currently Pregnant ◯ Yes ◯ No
  - Number of weeks:_______________
- Nursing ◯ Yes ◯ No

For office use:
Blood pressure:________________Pulse:_____________

MEDICATIONS

1.______________________________ 5.______________________________ 9.______________________________
2.______________________________ 6.______________________________ 10.______________________________
3.______________________________ 7.______________________________ 11.______________________________
4.______________________________ 8.______________________________ 12.______________________________

For office use:
Date Updated:__________Date Updated:__________Date Updated:__________Date Updated:__________Date Updated:__________