



MEDICAL HISTORY (Confidential)

Staci R. Blaha, D.D.S

Patient Name: _____ Date: _____

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 the following questions.

If you answer "yes" to any questions below, please specify:

- Are you under a physician's care now? Yes No _____
- Have you ever been hospitalized or had a major operation? Yes No _____
- Have you ever had a serious head or neck injury? Yes No _____
- Please list any medications, pills or drugs that you take? Yes No _____
- Do you take, or have you taken, Phen-Fen, Redux, Bisphosphonates? Yes No _____
- Do you need to premedicate? Yes No _____
- Do you have a tobacco addiction? Yes No _____
- Do you use controlled substances? Yes No _____

WOMEN: Are you Pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Sulfa Drugs Barbiturates Sedatives Iodine Other _____

Do you have, or have you had, any of the following?

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pacemaker* | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Tobacco Addiction |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sensitive Teeth/Gums | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sickle Cell Disease | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sinus Trouble | * Condition may require medication |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Spina Bifida | |
| <input type="checkbox"/> Cold Sores/Fever Blisters | | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach/Intestinal Disease | |
| | | <input type="checkbox"/> Low Blood Pressure | | |

Have you ever had any serious illness not listed above? Yes No _____

How often do you brush? _____ Floss? _____

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____

Doctor Comments: _____

Doctor Signature: _____ Date: _____