PATEL & DORNHECKER
DENTISTRY

MEDICAL HISTORY

Patient Name: _____ Date:_____

It is very important for you to fill out these medical questions to the best of your knowledge. Our goal is to make sure that your overall health is not compromised by the treatment we provide you. All conditions and health concerns marked are confidential and follow the HIPAA Privacy Act.

ALLERGIES:

Penicillin/Amoxicillin .....Y / N
Aspirin..... Y / N
Codeine..... Y / N
Dental Anesthetics…….....Y / N
Seasonal ..... Y / N
Latex..... Y / N
Tetracycline.....Y / N
Motrin/Ibuprofen…...……..Y / N
Metals…...……...Y / N
Other:
_____

NERVOUS SYSTEM / MENTAL ISSUES:

Anxiety…..... Y / N
History of Fainting….. ..... Y / N
Seizures/Epilepsy ..... Y / N
Nerve Pain/Numbness…..... ..... Y / N
Depression .... Y / N
ADD/ADHD ..... Y / N
Bipolar..... Y / N
Psychiatric Treatment……...…...……Y / N
Eating Disorder……..……...……Y / N
Have you had cosmetic surgery?….....….Y / N
Do you smoke? ..... Y / N
If so, how long have you smoked?_____
Do you chew tobacco? .....Y / N
Do you use recreational drugs?..…..... Y / N
Do you drink alcohol?..... Y / N
Have you had problems with Chemical Dependency?..... Y / N

HEART/BLOOD CONDITIONS:

Heart Attack/Stroke (date: _____) …..Y / N
Pacemaker ..... Y / N
Heart Murmur/Mitral Valve Prolapse…...Y / N
High/Low Blood Pressure …..... Y / N
High Cholesterol .....Y / N
Anemia ..... Y / N
Taking a Blood Thinner/Daily Aspirin..…Y / N

CONDITIONS:

Diabetes .....Y / N
Hepatitis A, B, C ..... Y / N
Excessive Bleeding….....Y / N
Stomach Ulcers…..……..……...Y / N
Liver Problems .....Y / N
Kidney Disease…….....Y / N
Digestive Issues .....Y / N
GERD/Acid Reflux…..……...……...Y / N
COPD ..... Y / N
Asthma .....Y / N
Breathing Problems…..……..…..Y / N
Sleep Apnea……...……...…..…..Y / N
History of cancer?..... Y / N
(type/date _____)
History of Radiation Treatment…...……....Y / N
History of Chemotherapy……...……..…..Y / N
HIV/Aids..... Y / N
Herpes or other STDs ..... Y / N
Osterporosis/Osteopenia...…...……..….Y / N
Arthritis……...…….....……..Y / N
Joint Replacement……...……..…..Y / N
(Type/Date)_____

For Women:

Are you pregnant? (weeks _____)..... Y / N
Are you nursing? ..... Y / N

Are you taking or have taken Oral Bisphosphates, e.g., FOSAMAX, ACTONEL, BONIVA or IV Bisphosphonates, e.g., ZOMETA, AREDIA?..... Y / N
Taken for how long?_____

Please list any medications, supplements, vitamins or over-the-counter medications you are currently taking:

1. _____for _____

2. _____for _____

3. _____for _____

4. _____for _____

5. _____for _____

6. _____for_____

7. _____for_____

8. _____for_____

9. _____for_____

10._____ for_____

NOTE: Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.
I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient Signature: **X** _____

Date: _____

For Office Use Only:

B.P._____

Notes: