

MEDICAL HISTORY APEX DENTAL

Date: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

PHYSICIAN'S NAME: _____ PHONE: _____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

- | | | | |
|-----|--|--|---|
| 1. | Do you consider yourself to be in good health? | YES | NO |
| 2. | Are you now or have you been under a physician's care within the past year?
<u>If Yes, specify condition being treated</u> _____ | YES | NO |
| 3. | Do you take any medications, including birth control pills?
Please specify name and purpose of medications: _____
_____ | YES | NO |
| 4. | Do you have or have you ever had any heart or blood problems? | YES | NO |
| 5. | Have you ever been told that you have a heart murmur? | YES | NO |
| 6. | Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? | YES | NO |
| 7. | Do you bleed or bruise easily? | YES | NO |
| 8. | Have you ever been diagnosed as being HIV positive or having AIDS? | YES | NO |
| 9. | Have you ever had hepatitis or liver disease? | YES | NO |
| 10. | Please circle any of the following you have had or have at the present: | | |
| | AIDS Related Complex
Anemia
Angina Pectoris
Arteritis
Artificial Heart Valve
Artificial Joint
Asthma
Blood Transfusion
Bruise Easily
Cancer
Chemotherapy
Cold Sores
Congenital Heart Failure
Diabetes | Drug Addiction
Emphysema
Epilepsy or Seizures
Eye Surgery
Fainting or Dizzy spells
Frequent Chest Pains
Glaucoma
Hay Fever
Hemophilia
Hepatitis
High Blood Pressure
HIV Positive
Kidney Trouble
Liver Disease | Heart Disease or Condition
Implant Prosthesis
Jaundice
Prolonged or Unusual Bleeding
Radiation Therapy
Rheumatic Fever
Shortness of Breath
Stroke
Swollen Ankles
Thyroid Disease
Tuberculosis
Ulcer
Unexplained Weight Loss |
| 11. | Have you ever had an unusual reaction or are you allergic to any of the following: | | |
| | Penicillin
Other antibiotics
Codeine or other narcotics
Acetaminophen | Sulfa Drugs
Barbiturates
Aspirin | Local Anesthetics
Metals/Jewelry
Other: _____ |
| 12. | Are you subject to fainting? | YES | NO |
| 13. | Have you ever had any severe reaction to dental treatment or local anesthetics? | YES | NO |
| 14. | Are you allergic to any local anesthetic? | YES | NO |
| 15. | Do you have any other allergies? <u>If Yes, please describe:</u> _____ | YES | NO |
| 16. | Have you ever had a nervous breakdown or undergone psychiatric treatment? | YES | NO |
| 17. | Have you ever received counseling for use of alcohol and/or prescription drugs? | YES | NO |
| 18. | Women: Are you pregnant? | YES | NO |
| 19. | Are you now in pain? | YES | NO |
| 20. | How long ago did you last see a dentist? _____ | | |
| 21. | Who was your previous dentist? _____ | | |
| 22. | Do you think that your teeth are affecting your general health in any way? | YES | NO |
| 23. | Do you have or have you ever had bleeding or sensitive gums? | YES | NO |
| 24. | Have you ever taken Phen-Fen or similar appetite suppressants?
<u>If Yes, have you seen your physician or cardiologist for a cardiac evaluation?</u> | YES | NO |
| 25. | Have you ever used or are you now using tobacco or alcohol? | YES | NO |
| 26. | Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease
The resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? | YES | NO |

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature _____
(Patient, legal guardian or authorized agent of patient)

Date _____

Doctor's Signature _____

Date _____