PROSTHODONTIC SPECIALISTS

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# PATIENT MEDICAL HISTORY

Patient's Name _____ Date ____/____/____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor (under 18 years)

***It is vitally important to the success of any dental treatment that all information on this form be completed in its entirety.***

Have you been admitted to a hospital or needed emergency care within the past two years? ☐ Yes ☐ No

If yes, please explain _____

Have you been treated by a physician within the past two years? (other than a routine visit) ☐ Yes ☐ No

If yes, please explain _____

Physician's Name _____ Phone Number _____

Please list current medications _____

_____

_____

Are you required to use pre-medication before dental treatment? ☐ Yes ☐ No

Do you smoke or chew tobacco? ☐ Yes ☐ No

**Your dental appointment *experience* is very important to our entire dental team. Please circle the number below that best describes you when visiting the dental office. Rating: 0 = No Reaction through 10 = Severe**

**Dental Anxiety** 0 1 2 3 4 5 6 7 8 9 10 **Gag Reflex** 0 1 2 3 4 5 6 7 8 9 10

Have you ever been prescribed bisphosphonates? (i.e. Actonel; Fosamax, etc.) ☐ Yes ☐ No
If yes, please explain _____

Have you ever had complications following dental treatment? ☐ Yes ☐ No

If yes, please explain _____

Please check if you have allergies to the following listed below:

| | | | | |
|---|---|---|---|---|
| ☐ Penicillin | ☐ Sulfa | ☐ Antibiotics | ☐ Codeine | ☐ Metals |
| ☐ Iodine | ☐ Aspirin | ☐ Latex | ☐ Local Anesthetics | |

Please list medications with allergic reactions _____

_____

**(please complete other side)**

Please check below if you ***have*** or ***have ever*** had the following

- ☐ Acid Reflux
- ☐ AIDS or HIV
- ☐ Alcohol Addiction
- ☐ Allergies (or Hives)
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Anorexia Nervosa
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (date___/___/___)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Body Dysmorphia
- ☐ Bruise Easily
- ☐ Bulimia
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Congenital Heart Defects
- ☐ Cortisone Medication
- ☐ Crohn's Disease
- ☐ Cushing's Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizzy Spells
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis (type ____)
- ☐ Herpes Virus
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Joint Pain (TMJ)
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Nervous/Anxiety Therapy
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Psychiatric Treatment
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sjogren's Syndrome
- ☐ Sleep Apnea (C-Pap)
- ☐ Snoring
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Do you have any disease(s) and/or conditions that are not listed above? ☐ Yes ☐ No
If yes, please explain _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain _____

_____

Women: Are you pregnant? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

**To the best of my knowledge, all of the preceding answers are true and correct. If any changes occur pertaining to my health or if my medications change, I will inform the dental practice of NC Prosthodontic Specialists during my next dental visit.**

_____ _____ _____
Patient's Signature Doctor's Signature Date