PACIFIC PROSTHODONTICS

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MEDICAL/HEALTH HISTORY

Patient Name_____ Date _____

Because dentistry frequently requires the use of drugs or invasive procedures, it is important that we have certain information about your health. All information on this form is strictly **CONFIDENTIAL**, and cannot be released to any other person or agency without your written permission. Please answer all of the following questions:

1. What is your estimate of your general health? (circle) POOR FAIR GOOD EXCELLENT

2. Have you been hospitalized during the past two years? Yes No
Reason? _____

3. Are currently under the care of a physician? Yes No Reason? _____

4. Physician & hospital 's name _____

5. Do you require antibiotics for any dental treatments? Yes No If YES what kind? _____

Cardiovascular Disorders:

Yes No
- ☐ ☐ High blood pressure
- ☐ ☐ Congenital Heart Disease
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Pacemaker
- ☐ ☐ Vascular graft
- ☐ ☐ Heart or bypass surgery
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Heart Attack
- ☐ ☐ Congestive Heart Failure
- ☐ ☐ Awaken with breathing difficulty
- ☐ ☐ Angina pectoris/chest pain
- ☐ ☐ Swollen ankles
- ☐ ☐ Irregular or rapid heart beats
- ☐ ☐ Stroke

Respiratory Disorders:

Yes No
- ☐ ☐ Emphysema or asthma
- ☐ ☐ Hay fever
- ☐ ☐ Chronic cough or bronchitis
- ☐ ☐ Tuberculosis
- ☐ ☐ Chronic sinusitis
- ☐ ☐ Breathing problems

Muscular-Skeletal/CNS Developmental Disorders:

Yes No
- ☐ ☐ Frequent headaches
- ☐ ☐ Fainting spells or loss of consciousness
- ☐ ☐ Seizures or epilepsy
- ☐ ☐ Visual impairment
- ☐ ☐ Hearing impairment
- ☐ ☐ Artificial joint
- ☐ ☐ Arthritis or bone disease
- ☐ ☐ Muscle disease
- ☐ ☐ Spinal cord injury or paralysis
- ☐ ☐ Cerebral palsy
- ☐ ☐ Mental retardation/autism
- ☐ ☐ Alzheimer's disease or other dementia

Other information not listed relevant to your dental care Yes ☐ No ☐ _____

Gastrointestinal/ Genitourinary Disorders:

Yes No
- ☐ ☐ Colitis or ulcers
- ☐ ☐ Hepatitis
  If yes type:
- ☐ ☐ Jaundice
- ☐ ☐ Renal dialysis/transplant
- ☐ ☐ Kidney disease
- ☐ ☐ Syphilis, gonorrhea or other sexually transmitted disease
- ☐ ☐ Genital herpes
- ☐ ☐ Frequent canker sore
- ☐ ☐ Chronic diarrhea
- ☐ ☐ Frequent vomiting

Hematologic/ Endocrine/ Immune Disorders:

Yes No
- ☐ ☐ Blood transfusion
- ☐ ☐ Anemia/leukemia/lymphoma
- ☐ ☐ Hemophilia
- ☐ ☐ Sickle Cell Disease
- ☐ ☐ Blood clots or thrombosis
- ☐ ☐ Diabetes
  If yes type:
- ☐ ☐ Thyroid disease
- ☐ ☐ Adrenal gland disease
- ☐ ☐ HIV
- ☐ ☐ AIDS
- ☐ ☐ Kaposi's Sarcoma
- ☐ ☐ Bleeding or bruising easily
- ☐ ☐ Sudden weight loss or gain
- ☐ ☐ Frequent thirst
- ☐ ☐ Frequent hunger
- ☐ ☐ Frequent urination
- ☐ ☐ Systemic lupus

Psychiatric:

Yes No
- ☐ ☐ Nervousness
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Past/present psychiatric treatment

Family history (Grandparents, Parents, Sisters, Brothers, Children):

Yes No
- ☐ ☐ Diabetes
- ☐ ☐ Heart Disease
- ☐ ☐ Bleeding disorder
- ☐ ☐ Cancer

Allergies:

Yes No
- ☐ ☐ Penicillin
- ☐ ☐ Sulfa drugs
- ☐ ☐ Novocain/Xylocaine/ other dental anesthetics
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Latex products
- ☐ ☐ Others: _____

Females:

Yes No
- ☐ ☐ Pregnant
- ☐ ☐ Taking birth control
- ☐ ☐ Anticipate becoming pregnant
- ☐ ☐ Breast feeding

Cancer:

Yes No
- ☐ ☐ Diagnosis _____
  Year _____
- ☐ ☐ Surgery
- ☐ ☐ Radiation
- ☐ ☐ Chemotherapy _____
  _____
  _____

Medications:

Yes No
- ☐ ☐ _____
  _____
  _____

Social history:

Yes No
- ☐ ☐ Smoking years
- ☐ ☐ Alcohol years
- ☐ ☐ Substance abuse years

I certify that the above information is correct to the best of my knowledge. I agree to keep this office informed of any changes in my health or any medical conditions I may be taking.

SIGNED _____ **DATE** _____