PATIENT MEDICAL HISTORY

PATIENT NAME: ________________________________ **DATE OF BIRTH:** ______________ **SEX:** ________

If you are completing this form for the above patient: ____
Your Name

____
Relationship to Patient

MEDICAL HISTORY

HEIGHT: ________________ **WEIGHT:** ________________ **BLOOD PRESSURE:** ______________

Physician's Name: ____
Address: ____ Phone #: ________________________

WOMEN:
Are you pregnant? YES / NO
If yes, when is your due date? ______________________ Who is your OB/GYN? ______________________
Are you nursing? YES / NO

Do you have, or have you ever had any of the following: (YES or NO)

	YES	NO		YES	NO		YES	NO		YES	NO
1 Artificial (prosthetic) Heart Valve	☐	☐	13 Anorexia	☐	☐	29 Drug Dependency	☐	☐	45 Autoimmune Disease	☐	☐
2 Previous Infective Endocarditis	☐	☐	14 Bulimia	☐	☐	30 Chemical Dependency	☐	☐	46 Artifical Joint / Prosthesis	☐	☐
3 Damaged Valves in Transplanted Heart	☐	☐	15 Lung disease / COPD	☐	☐	31 Blood Disorders	☐	☐	47 Liver Disease	☐	☐
4 Congenital Heart Disease (CHD)			16 Tuberculosis	☐	☐	32 Anemia	☐	☐	48 Hepatitis (circle one)	☐	☐
Unrepaired, Cyanotic CHD	☐	☐	17 Asthma	☐	☐	33 Leukemia	☐	☐	Type A B C Other		
Repaired (completely) in last 6 months	☐	☐	18 Shortness of Breath	☐	☐	34 Prolonged Bleeding	☐	☐	49 Ulcers	☐	☐
Repaired CHD with residual defects	☐	☐	19 Respiratory Ailments	☐	☐	35 Hemophilia	☐	☐	50 Gastrointestinal Disease	☐	☐
5 Heart Disease/Surgery	☐	☐	20 Emphysema	☐	☐	36 Sickle Cell Disease	☐	☐	51 GERD (gastric reflux)	☐	☐
6 Heart Murmur	☐	☐	21 Sinus Trouble	☐	☐	37 Cancer	☐	☐	52 Hearing Impaired	☐	☐
7 Heart Pacemaker	☐	☐	22 Diabetes Type I or Type II	☐	☐	38 Tumors	☐	☐	53 Glaucoma	☐	☐
8 Rheumatic Fever/Heart Disease	☐	☐	23 Thyroid Problems	☐	☐	39 Chemotherapy	☐	☐	54 Cortisone Medication	☐	☐
9 Mitral Valve Prolapse	☐	☐	24 Persistent swollen glands	☐	☐	40 Radiation Therapy	☐	☐	55 Fainting Spells	☐	☐
10 High/Low Blood Pressure	☐	☐	25 Kidney Problems	☐	☐	41 Neurological Disorders	☐	☐	56 Organ Transplant	☐	☐
11 Learning Disability	☐	☐	26 Venereal Disease	☐	☐	42 Epilepsy	☐	☐	57 Removal of Spleen	☐	☐
12 Mental Health Disorder	☐	☐	27 HIV Positive / AIDS / ARC	☐	☐	43 Stroke	☐	☐	58 Osteoporosis	☐	☐
	☐	☐	28 Alcohol Addiction	☐	☐	44 Arthritis / Rheumatism	☐	☐	59 Sleep Disorder	☐	☐

ALLERGIES/SENSITIVITIES

Are your allergic /sensitive to (or had an adverse reaction) to:
Check all that apply or check none:

- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Latex
- ☐ Other ______________________

Have you had any other serious illness, hospitalization or accident? YES / NO

If yes, please explain:

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NOTES:

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PRE-MEDICATION NEEDED? YES / NO Reason: ________________________________

If yes, Regimen: 2 g Amoxicillin one hour prior to dental appointment
600 mg Clindamycin one hour prior to dental appointment

Other: ____

CURRENT MEDICATIONS:

LIST ALL MEDICATIONS PRESCRIBED BY YOUR PHYSICIAN
(including birth control pills), vitamins, herbal supplements,
over-the-counter drugs taken routinely.

REASON FOR MEDICATION (e.g. diabetes, high blood pressure…)

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BISPHOSPHONATES
Have you ever taken, are you currently taking or scheduled to begin taking any of the following medications: alendronate (FOSAMAX), risedronate (ACTONEL), or ibandronate (BONIVA) for osteoporosis or Paget's disease? YES / NO

Were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (AREDIA or ZOMETA) for bone pain, hypercalcemia of skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? YES / NO Date treatment began: ______/________/_________

TOBACCO USE: Have you ever or do you currently use tobacco products? YES / NO How much? _____________________ How often? ___________________

Circle all that apply: Cigarettes Cigars Pipe Chew How long ago did you quit? ____________________________

ALCOHOL USE: Do you drink alcoholic beverages? How much? ____________________________ How often? _______________________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective care provider or agency, who may release such information to you. I will notify Drs. Heringhaus of any changes in my health or medication.

Patient Signature: ____ Date ______________________
(Parent/Guardian if minor)

MEDICAL HISTORY UPDATED: (Note date and changes)

____ /_____ /______ ____
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