PECAN PARK FAMILY DENTISTRY

MEDICAL HISTORY FORM

Patient Name_____ DOB _____ Date _____

Physician's Name and specialty_____

Most recent examination _____ Purpose _____

What is your estimate of your general health? O Excellent O Good O Fair O Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
Hospitalization for illness or injury_____	O	O	Frequent Headaches	O	O
Heart problems or cardiac stent _____	O	O	Any lumps or swellings in the mouth _____	O	O
History of infective endocarditis_____	O	O	Hepatitis (Type _____) _____	O	O
Artificial heart valve, repaired heart defect _____	O	O	HIV/AIDS _____	O	O
Pacemaker or implantable defibrillator _____	O	O	Tumor, abnormal growth _____	O	O
Artifical prosthesis (heart valve or joint)_____	O	O	Radiation therapy _____	O	O
Rheumatic or scarlet fever _____	O	O	Chemotherapy _____	O	O
High or low blood pressure _____	O	O	Emotional problems _____	O	O
Stroke _____	O	O	Psychiatric treatment _____	O	O
Taking blood thinners _____	O	O	Antidepressant medication _____	O	O
Prolonged bleeding from small cut (INR >3.5) _____	O	O	Alcohol/drug dependency _____	O	O
Anemia or other blood disorder _____	O	O	Chewing tobacco/dip habit _____	O	O
Tuberculosis _____	O	O			
Emphysema, sarcoidosis _____	O	O	Allergic reaction to:		
Asthma _____	O	O	Aspirin, Ibuprofen, Tylenol _____	O	O
Breathing or sleep problems (snoring, sinus) _____	O	O	Codeine_____		
Kidney disease _____	O	O	Penicillin _____	O	O
Liver disease _____	O	O	Clindamycin _____	O	O
Jaundice _____	O	O	Sulpha _____	O	O
Thyroid, parathyroid disease or calcium deficiency _	O	O	Fluoride_____	O	O
Hormone deficiency_____	O	O	Metals (i.e. nickel, gold, _____)	O	O
High cholesterol or taking statin drugs _____	O	O	Latex _____	O	O
Diabetes (HbA1c = _____) _____	O	O	Other (_____)	O	O
Stomach or duodenal ulcer _____	O	O	**I HAVE NO KNOWN ALLERGIES**	O	O
Digestive disorders (i.e. gastric reflux) _____	O	O			
Neurologic problems (i.e. ADD, ADHD) _____	O	O			
Viral infections or cold sores _____	O	O	**ARE YOU:**	O	O
Arthritis _____	O	O	Presently being treated for any other illness__	O	O
Glaucoma _____	O	O	Aware of a change in your general health ___	O	O
Contact lenses _____	O	O	Taking dietary supplements _____	O	O
Head or neck injuries _____	O	O	Smoker or previous smoker _____	O	O
Epilepsy, convulsions, seizures _____	O	O	FEMALE-pregnant _____	O	O
Osteoporosis/osteopenia _____	O	O	FEMALE-taking birth control pills _____	O	O
Have taken medicine for osteoporosis (i.e. Fosamax, Boniva, etc.) _____	O	O	MALE-prostate disorders _____	O	O

Describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment: _____

_____

List all medications, supplements, and/or vitamins taken within the last two years: _____

_____

_____

I certify that the above information is complete and correct.

Patient's signature:_____ Date: _____

Doctor's signature: _____ Date:_____