MEDICAL HISTORY

We appreciate the confidence you place with us to provide dental services. Assist us in serving you by completing the following form. In the future, notify us of any changes in your health.

Patient Name: _____ **Date of Birth:** ___/___/___ **Age:** _____

Primary M.D.: _____
Address: _____
_____
Phone: (___) _____

Secondary M.D.: _____
Address: _____
_____
Phone: (___) _____

Prior Dentist: _____
Last dental visit: _____
Last medical visit: _____

PLEASE CIRCLE "YES" OR "NO" ON EACH OF THE FOLLOWING

Cardiovascular Problems
- Artificial heart valve _____ Yes No
- History of infective endocarditis _____ Yes No
- Certain specific, serious, congenital heart conditions (from birth)
  - Cyanotic congenital heart disease: Unrepaired or incompletely repaired (shunts and conduits?) _____ Yes No
  - Completely repaired congenital heart defect with prosthetic material or device (less than six months) Yes No
  - Repaired congenital heart defect with residual defect at or adjacent to the site of prosthetic patch/device Yes No
- Cardiac transplants that develop valve problems Yes No

- Arteriosclerosis _____ Yes No
- Blood pressure problem _____ Yes No
  - Usual Blood Pressure: ____/____
- Chest pain upon exertion _____ Yes No
- Congenital heart malformations _____ Yes No
- Coronary occlusion or insufficiency _____ Yes No
- Heart attack - If yes, when? _____ Yes No
- Heart murmur _____ Yes No
- Heart surgery _____ Yes No
- Hypertrophic cardiomyopathy _____ Yes No
- Mitral valve prolapse with valvular regurgitation _____ Yes No
- Pacemaker _____ Yes No
- Rheumatic or other acquired heart valve problems _____ Yes No
- Stroke - If yes, when? _____ Yes No

Blood Problems
- Abnormal bleeding history _____ Yes No
- Blood disease (anemia) _____ Yes No

Liver Problems
- Hepatitis _____ Yes No

Kidney Problems _____ Yes No

Allergy Problems _____ Yes No

Respiratory
- Asthma, Emphysema, COPD (circle one) _____ Yes No
- Tuberculosis _____ Yes No

Bone or Joint Problems
- Arthritis _____ Yes No
- Joint replacement - If yes, when? _____ Yes No

Neurological
- Seizures or Epilepsy _____ Yes No

Diabetes _____ Yes No

Cancer/Tumor (Past or Present) _____ Yes No
- Radiation: Head/Neck Region (Past or Present) _____ Yes No
- Chemotherapy: (Past or Present) _____ Yes No

Herpes, HIV+, AIDS _____ Yes No

Alcoholism _____ Yes No

Tobacco
- Do you smoke or chew tobacco? _____ Yes No
- How Much? _____

Are you allergic to or have you reacted adversely to any of the following:
- Codeine, barbiturates, sedatives, sleeping pills _____ Yes No
- Latex _____ Yes No
- Local anesthetics ("Novocain") _____ Yes No
- Penicillin or other antibiotics _____ Yes No
- Other _____

Are you taking any of the following:
- Antibiotics or sulfa drugs _____ Yes No
- Anticoagulants (blood thinners), aspirin _____ Yes No
- Antidepressants _____ Yes No
- Cortisone (steroids) _____ Yes No
- Digitalis, Nitroglycerin, or drugs for heart trouble _____ Yes No
- High blood pressure medicine _____ Yes No
- Insulin, Orinase, or similar drug _____ Yes No
- Tranquilizers _____ Yes No
- List Medications: _____
  _____

Are you taking, or have you ever taken bisphosphonates for chemotherapy or osteoporosis:
- Actonel, Boniva, Fosamax, IV Aredia, IV Zometa _____ Yes No

Women
- Are you taking contraceptives or other hormones? _____ Yes No
- Are you pregnant? _____ Yes No
  - If so, expected delivery date: ____/____/____

Do you have any diseases or conditions not listed above?
If so, please explain: _____
_____
_____

Have you ever had adverse reactions with dental treatment?
If so, please explain: _____
_____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at future appointments. I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff.

_____ ___/___/___
Signature: Patient / Parent / Guardian **Date**

Dr. Chase Initials: _____ ___/___/___