Leo Family DENTAL

MEDICAL HEALTH HISTORY

Name _____ Date of Birth _____

Address _____

Phone# _____ Mobile# _____

Primary Physician _____ Physician Office Phone# _____

Approximate date of last physical examination _____

Do you have, or have you had, any of the following?

Heart Problems	Yes	No
Chest pain	◯	◯
Shortness of breath	◯	◯
Blood pressure problem	◯	◯
Heart murmur	◯	◯
Heart valve problem	◯	◯
Artificial heart valve	◯	◯
Rheumatic fever	◯	◯
Pacemaker	◯	◯

Blood Problems		
Bruises easily	◯	◯
Frequent nosebleeds	◯	◯
Abnormal bleeding	◯	◯
Blood diseases (anemia)	◯	◯

Allergy Problems		
Hay fever	◯	◯
Sinus problems	◯	◯
Skin rashes	◯	◯
Asthma	◯	◯

Intestinal Problems		
Ulcers	◯	◯
Weight gain or loss	◯	◯
Special diet	◯	◯
Constipation/Diarrhea	◯	◯
Kidney or bladder problems	◯	◯

Bone or Joint Problems		
Arthritis	◯	◯
Back or neck pain	◯	◯
Joint replacement (e.g., total hip, pins, or implants)	◯	◯

Diabetes	Yes	No
Urinate more than 6 times a day	◯	◯
Thirsty or mouth is often dry	◯	◯
Family history of diabetes	◯	◯

Fainting Spells, Seizures, or Epilepsy	◯	◯
Stroke(s)	◯	◯
Frequent or severe headaches	◯	◯
Thyroid problems	◯	◯
Persistent cough or swollen glands	◯	◯
Premedications required by physician	◯	◯
Cancer/Tumor	◯	◯
Radiation treatments	◯	◯
Tuberculosis or other respiratory disease	◯	◯
Do you drink alcohol?	◯	◯
If so, how much? _____		
Do you smoke?	◯	◯
If so, how much? _____		
Hepatitis, jaundice, or liver trouble	◯	◯
Herpes or other STD	◯	◯
HIV-positive/AIDS	◯	◯
History of head injury?	◯	◯
Neurological problems?	◯	◯
History of alcohol or drug abuse?	◯	◯

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe:

_____

_____

Have you ever taken any of the following?	Yes	No
Antibiotics or sulfa drugs	◯	◯
Anticoagulants (e.g., Coumadin)	◯	◯
High blood pressure medicine	◯	◯
Tranquilizers	◯	◯
Insulin, Orinase, or similar drug	◯	◯
Aspirin	◯	◯
Digitalis or drugs for heart trouble	◯	◯
Nitroglycerin	◯	◯
Cortisone (steroids)	◯	◯
Natural remedies	◯	◯
Nonprescription drug/supplements	◯	◯
Bisphosphonates (e.g., Fosamax, Boniva, Actonel)	◯	◯

Women	Yes	No
Are you taking contraceptives or other hormones?	◯	◯
Are you pregnant?	◯	◯
If so, expected delivery date: _____		
Are you nursing?	◯	◯
Have you reached menopause?	◯	◯

If so, do you have any symptoms?

_____

_____

_____

List of Medications (If you have a printed list, we can photocopy it for your convenience.)

_____

_____

_____

_____

_____

_____

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics ("Novocaine")	◯	◯
Penicillin or other antibiotics	◯	◯
Sulfa drugs	◯	◯
Barbituates, sedatives, or sleeping pills	◯	◯
Aspirin, Acetaminophen, or Ibuprofen	◯	◯
Codeine, Demerol, or other narcotics	◯	◯
Reaction to metals	◯	◯
Latex or rubber	◯	◯
Other _____		

Notes: _____

_____

_____

_____

Patient/Parent Print Name: _____

Patient/Parent Signature: _____

Date: _____ Dentist Initial: _____