Barth Family Dentistry, PSC-- Full Length Medical History Form

Patient's Name: _____ Date of Birth: _____ Height:_____ Weight: _____
Medical Physician's Name, Phone Number, & Address: _____
Cardiologist's Name, Phone Number & Address: _____
OBGYN's Name, Phone Number & Address: _____
Pharmacy & Location: _____ Pharmacy Phone# _____
Your Primary Language: _____

*** Please Mark any conditions past or present that apply to you! Answers are completely confidential.**

__***Previous Endocarditis*** *Date:* _____
__***Artifical Heart Valve*** *Date:* _____
__***Artifical Joint Replacement*** *Type:*_____ *Date:*_____
Complications: _____
__***Congenital Heart Defect***
__**AV Shunt/Patent Ductus Arteriosis**
__***Transplant*** *Type:*_____ *When:* _____
__***Any Heart Valve Damage*** *Type*_____ *When*_____
__**Mitral Valve Prolapse,** *Complications?* _____
__ Pacemaker
__ Angina pectoris/Chest pain
__ High Blood Pressure
__ Irregular Heart Beat
__ Heart disease or attack
__ Diabetes Type 1 or 2
__ Tendency to Bleed/Blood Thinner
__ Hemophilia
__ Anemia
__ Sickle Cell Disease/ Trait
__ Hearing Impaired
__ Glaucoma or Cataract
__ Tobacco: Packs per Day? _____
__ Alcohol: Drinks per Week? _____
__ Stroke (Major or Minor)
__ Has a Living Will *(Please give to the receptionist)*
__ Any Conditions not listed here: _____
__ Victim of Violence/Rape/Abuse: *Date:* _____ *Type:* _____
__ I want and I am willing to accept HELP/Counseling for Domestic Violence/ Rape/ Abuse of any kind?

__ Currently Pregnant …*Due Date:* _____
__ Currently Nursing/ Breast Feeding
__ Currently Taking Birth Control Pills…*Type*: _____
__ Disability of Any Kind …*Type*: _____
__ Thyroid Disease
__Taken Prednisone/Steroids…*Type/Dates:* _____
__ Nervousness/Anxiety
__ Psychiatric Treatment… *Doctor/Hospital:* _____
__ Sinus Issues
__ Drug Addiction (Any Type)…*Type:* _____
__ Epilepsy, seizures
__ Emphysema
__ Tuberculosis (TB)… *Circle: Active or Non-Active*
__ Asthma
__ Kidney/ Bladder conditions
__ Dialysis
__ HIV-Positive/AIDS…*Counts: CD4* _____ *Viral Load*_____
__ Sexually Trans. Disease *Type*: _____
__ Tumor or Cancer. *Type:* _____
__ Chemotherapy, *When*: _____
__ Radiation Therapy… *Date:* _____ *Entry/Exit Point:* _____
__ Hepatitis/ yellow jaundice…*Type:* _____
__ Cirrhosis of Liver
__ Anorexia or Bulimia
__ Acid Reflux or GERD
__ Digestive Conditions …*Type:* _____

ARE YOU ALLERGIC TO:

__Latex (rubber)
__Local Anesthetics, Type: _____
__Penicillin
__Aspirin
__Codeine
__Food, Wine, Animal, Preservative, _____
List any other drug allergies: _____
_____

__ DENTAL HISTORY:

__ I have a dental check up twice a year?
__ My teeth feel loose or hurt when biting?
__ My gums bleed when brushing?
__ I have pain or popping of jaw joint?
__ Have you ever worn braces or false teeth? _____
__ Drink more than 2 soft drinks a day?
__ Work with blood products or needles?
How many times a **WEEK** do you? Brush ____ Floss _____

__ Hospitalizations/Surgeries*: (Lists Dates & Why?):* _____

List any medications & dosage:_____ _____
_____

To the best of my knowledge, the stated responses are correct and true. If there are any changes in the my health history, I will inform the dentist at beginning of the next appointment.

_____ _____ _____
Signature: Patient/Parent/ Legal Guardian Date Witness

Updated Jan. 1, 2016