

### PATIENT MEDICAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

- 1. Are you under any medical treatment now? ..... yes no
- 2. Have you had any major operations? ..... yes no  
If so, what? \_\_\_\_\_
- 3. Have you ever had a serious accident? ..... yes no
- 4. Do you have or have you had any of the following diseases?
  - a. Rheumatic fever or Rheumatic heart disease ..... yes no
  - b. Congenital heart lesions ..... yes no
  - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke, heart murmur, palpitations) ..... yes no
  - d. Emphysema, asthma, or hay fever ..... yes no
  - e. Hives or skin rash ..... yes no
  - f. Fainting spells or seizures ..... yes no
  - g. Diabetes ..... yes no
  - h. Hepatitis, jaundice, liver disease ..... yes no
  - i. Arthritis, inflammatory rheumatism (painful swollen joints) ..... yes no
  - j. Stomach ulcers or intestinal problems ..... yes no
  - k. Kidney trouble ..... yes no
  - l. Tuberculosis, persistent cough or coughing up blood ..... yes no
  - m. High or low blood pressure ..... yes no
  - n. Venereal or sexually transmitted diseases ..... yes no
  - o. Allergies ..... yes no
  - p. Tumors, growths, or cancers ..... yes no
  - q. AIDS or have tested positive to HIV ..... yes no
- 5. Do you have pain in the chest upon exercise? ..... yes no
- 6. Are you ever short of breath after mild exercise ..... yes no
- 7. Do your ankles swell? ..... yes no
- 8. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ..... yes no
- 9. Do you have to urinate (pass water) more than six times a day? ..... yes no
- 10. Does your mouth frequently become dry? ..... yes no
- 11. Are you thirsty much of the time? ..... yes no
- 12. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
  - a. Do you have any blood disorders? ..... yes no
  - b. Do you bruise easily? ..... yes no
  - c. Have you ever required a blood transfusion? ..... yes no
- 13. Are you taking any of the following?
  - a. Antibiotics or sulfa drugs ..... yes no
  - b. High blood pressure medicine or anticoagulants (blood thinners) ..... yes no
  - c. Cortisone (steroids) ..... yes no
  - d. Tranquilizers ..... yes no
  - e. Aspirin, anacin, bufferin ..... yes no
  - f. Insulin, tolbutamide (orinase) or similar drug ..... yes no
  - g. Nitroglycerin, digitalis, or drugs for heart trouble ..... yes no
  - h. Birth control pills ..... yes no
  - i. Bisphosphonates (osteoporosis/Cancer drugs) ex. Zometa, Aredia, Fosamax..... yes no
  - j. Other ..... yes no
- 14. Are you allergic or have you reacted adversely to:
  - a. Local anesthetics ..... yes no
  - b. Sulfa drugs, penicillin, or other antibiotics ..... yes no
  - c. Barbiturates, sedatives or sleeping pills? ..... yes no
  - d. Aspirin ..... yes no
  - e. Codeine or other narcotics ..... yes no
  - f. Other? ..... yes no
- 15. Do you use alcohol or other recreational drugs on a daily/weekly basis ..... yes no
- 16. Are you employed in any situation which exposes you regularly to x-rays or other Ionizing radiation? ..... yes no
- 17. Are you pregnant? ..... yes no
- 18. Do you have any diseases, conditions or problems not listed above that you think I should know about? ..... yes no

Signature: \_\_\_\_\_