Abriani Smiles

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MEDICAL HISTORY

This Medical History is confidential and necessary for our files and your Health!

I. Select each appropriate answer (leave blank if you do not understand the question).

☐ Yes ☐ No Is your general heath good? If no explain why:

Date of last medical exam: _____ Date of last dental exam: _____

☐ Yes ☐ No Has there been a change in your health within the last year?

☐ Yes ☐ No Are you being treated by a physician now? If yes explain:

☐ Yes ☐ No Have you been hospitalized or had a serious illness in the last three years?
If yes explain: _____

II. Have you experienced:

☐ Yes ☐ No Chest pain (angina)?
☐ Yes ☐ No Swollen ankles?
☐ Yes ☐ No Shortness of breath?
☐ Yes ☐ No Recent weight loss, fever, night sweats?
☐ Yes ☐ No Persistent cough, coughing up blood?
☐ Yes ☐ No Bleeding problems, bruising easily?
☐ Yes ☐ No Sinus problems?
☐ Yes ☐ No Difficulty swallowing?
☐ Yes ☐ No Diarrhea, constipation, blood in the stools?
☐ Yes ☐ No Frequent vomiting, nausea?
☐ Yes ☐ No Difficulty urinating, blood in urine?
☐ Yes ☐ No Frequent Neck Pain?
☐ Yes ☐ No Metal allergies (irritation from jewelry)
☐ Yes ☐ No Skin diseases?
☐ Yes ☐ No Headaches?
☐ Yes ☐ No Fainting spells/dizziness?
☐ Yes ☐ No Blurred vision?
☐ Yes ☐ No Seizures?
☐ Yes ☐ No Excessive thirst? Urination?
☐ Yes ☐ No Dry mouth?
☐ Yes ☐ No Stomach problems/ulcer?
☐ Yes ☐ No Joint pain, TMJ syndrome?
☐ Yes ☐ No Shingles?
☐ Yes ☐ No Back problems?

III. Do you have or have you had:

☐ Yes ☐ No Heart murmur?
☐ Yes ☐ No Heart surgery/pacemaker?
☐ Yes ☐ No Mitral valve prolapse?
☐ Yes ☐ No Heart disease? Heart attack?
☐ Yes ☐ No Congenital heart defects?
☐ Yes ☐ No Rheumatic fever?
☐ Yes ☐ No Blood disorders (sicle cell/hemophilla, ITP?)
☐ Yes ☐ No Stroke, hardening of arteries?
☐ Yes ☐ No High blood pressure?
☐ Yes ☐ No Scarlet Fever?
☐ Yes ☐ No TB emphysema, other lung disease?
☐ Yes ☐ No Hepatitis, other liver diseases?
☐ Yes ☐ No **Allergies** (to medication, food, environmental)?
☐ Yes ☐ No Family history of diabetes, heart problems?
☐ Yes ☐ No Artificial joints/pins/screws? When?
☐ Yes ☐ No Prescription for diet suppressant pills (ex: Fen-Phen)?
☐ Yes ☐ No Prosthetic heart valve?
☐ Yes ☐ No Psychiatric Care?
☐ Yes ☐ No Radiation Treatments?
☐ Yes ☐ No Xray or Cobalt Treatment?
☐ Yes ☐ No Leukemia
☐ Yes ☐ No Ringing in ears/Hearing disorders?
☐ Yes ☐ No Artificial valves?
☐ Yes ☐ No Yellow jaundice?
☐ Yes ☐ No HIV/AIDS?
☐ Yes ☐ No Tumors, cancer?
☐ Yes ☐ No Arthritis? Rheumatis?
☐ Yes ☐ No Eye diseases?
☐ Yes ☐ No Psychiatric problems?
☐ Yes ☐ No Anemia?
☐ Yes ☐ No VD (syphilis or gonorrhea)?
☐ Yes ☐ No Cold sores or fever blisters?
☐ Yes ☐ No Herpes?
☐ Yes ☐ No Kidney, bladder diseases?
☐ Yes ☐ No Thyroid, adrenal disease?
☐ Yes ☐ No Diabetes?
☐ Yes ☐ No Chemotherapy?
☐ Yes ☐ No Hospitalization?
☐ Yes ☐ No Blood Transfusions?
☐ Yes ☐ No Surgeries?
☐ Yes ☐ No Pacemaker?
☐ Yes ☐ No Contact Lenses?
☐ Yes ☐ No Asthma
☐ Yes ☐ No Glaucoma

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V. Are you taking?

☐ Yes ☐ No **Drugs, Medications** (including aspirin and any other the counter medications or remedies including osteoporosis?

☐ Yes ☐ No Recreational Drugs?
☐ Yes ☐ No Tobacco in any form?
☐ Yes ☐ No Alcohol?

VI. Women Only

☐ Yes ☐ No Are you (or could you be) Pregnant?

☐ Yes ☐ No Are you taking birth control pills? If yes name them:

VII. All Patients:

☐ Yes ☐ No Do you have or had any other diseases or medical problems NOT listed on this form (Ex: Alzheimer's?)

VIII. Are you allergic to any of the following?

☐ Yes ☐ No Latex
☐ Yes ☐ No Tetracycline
☐ Yes ☐ No Penicillin/Amoxicillin
☐ Yes ☐ No Aspirin

To the best of my knowledge I have answered every question on this form completely and accurately. I will inform my dentist of any change In my health and/or medication.

Patient Signature: _____ Date: _____

Print Name: _____ Dentist Signature: _____

List medications that you are taking and for what condition: _____

_____

_____