East Main Dental Center, LLP

MEDICAL HISTORY

GREGORY L. PEARSON, DMD
HAL L. BORG, DMD
CALIE ROA, DMD
ERIC N. ALSTON, DMD
KENNETH D. McGOWAN, DMD

PATIENT _____ DATE _____

DATE OF BIRTH _____

NAME OF PHYSICIAN _____ PHONE _____

WHOM MAY WE NOTIFY IN CASE OF AN EMERGENCY? Name _____ PHONE _____ Relationship to you _____

Circle a definite answer for each question:

Yes No ANY CHANGE IN YOUR HEALTH IN THE LAST TWO YEARS?

Yes No ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?

IF YES, DESCRIBE YOUR TREATMENT: _____

Yes No HAVE YOU HAD ANY MEDICAL TREATMENT OR PHYSICIAN VISIT OF ANY KIND IN THE LAST TWO YEARS?

IF YES, DESCRIBE: _____

Yes No HAVE YOU EVER HAD ANY SURGICAL OPERATION OF ANY KIND? IF YES, DESCRIBE: _____

Yes No HAVE YOU BEEN ADVISED BY A PHYSICIAN OF THE NEED FOR ANY TYPE OF SURGERY OR TREATMENT?

FOR WHAT? _____

DO YOU HAVE, HAVE YOU HAD, OR BEEN TREATED FOR, ANY OF THE FOLLOWING?:

Yes	No	HEART PROBLEMS	Yes	No	GLAUCOMA
Yes	No	RHEUMATIC FEVER	Yes	No	DIABETES
Yes	No	HEART MURMUR	Yes	No	KIDNEY DISORDER
Yes	No	MITRAL VALVE PROLAPSE	Yes	No	SHUNTS
Yes	No	HEART VALVE REPLACEMENT	Yes	No	HEPATITIS A:__ B:__ C:__
Yes	No	PACEMAKER TYPE	Yes	No	TUBERCULOSIS
Yes	No	HIGH BLOOD PRESSURE	Yes	No	HERPETIC COLD SORES
Yes	No	LOW BLOOD PRESSURE	Yes	No	ULCERS
Yes	No	ANEURYSM	Yes	No	THYROID CONDITION
Yes	No	HIP OR JOINT REPLACEMENT	Yes	No	MALIGNANT HYPOTHERMIA
Yes	No	ANOREXIA, BULIMIA	Yes	No	ARTHRITIS
Yes	No	CHEMICAL DEPENDENCY	Yes	No	ASTHMA
Yes	No	ANEMIA	Yes	No	CHRONIC SINUS, EAR INFECTIONS
Yes	No	HEMOPHILIA, BLEEDING OR BLOOD DISORDER	Yes	No	RADIATION OR CHEMICAL THERAPY
			Yes	No	OSTEOPOROSIS OR OTHER BONE DISORDER?
Yes	No	EPILEPSY, SEIZURES			

BLOOD PRESSURE	DATE

Yes No ARE YOU TAKING OR HAVE YOU TAKEN BISPHOSPHONATES? (Example: Fosamax, Zometa, Aredia)

Yes No HAVE YOU EVER BEEN TOLD THAT YOU NEED TO TAKE ANTIBIOTICS OR ANY OTHER MEDICINE BEFORE DENTAL TREATMENT?

Yes No HAVE YOU EVER HAD AN ALLERGIC REACTION OR BEEN TOLD NOT TO TAKE ANY MEDICATION? IF YES, DESCRIBE (i.e. penicillin)

_____

Yes No HAVE YOU EVER EXPERIENCED A SKIN REACTION TO JEWELRY OR LATEX? _____

Yes No ARE YOU CURRENTLY TAKING ANY PRESCRIPTION DRUGS OF ANY KIND (Example: Birth Control, Hormone, Diet)? IF YES, WHAT?

_____

Yes No ARE YOU CURRENTLY TAKING ANY NONPRESCRIPTION DRUGS OF ANY KIND (Example: Aspirin, Cough Syrup, Nasal Spray, Recreational Drug Use, Sugar, Caffeine)? IF YES, WHAT? _____

Yes No HAVE YOU BEEN TESTED FOR THE HIV VIRUS? IF YES, WHAT WAS THE TEST: ❒ POSITIVE ❒ NEGATIVE

Yes No ARE YOU PREGNANT? ANTICIPATED DELIVERY DATE: _____

Yes No DO YOU USE ANY TOBACCO OR ALCOHOL PRODUCTS? DAILY INTAKE: _____

Yes No HAVE YOU EVER EXPERIENCED ANY UNFAVORABLE REACTIONS TO DENTAL PROCEDURES? _____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____

Patient or Guardian of Minor

COMMENTS: