Westbank Dental

MEDICAL HISTORY FORM

Patient Name____________________________________ DOB ___________________ Date _____________

Physician's Name and specialty____

Most recent examination ____________________________ Purpose _________________________________

What is your estimate of your general health? O Excellent O Good O Fair O Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
Hospitalization for illness or injury_______________	O	O
Heart problems or cardiac stent ________________	O	O
History of infective endocarditis_________________	O	O
Artificial heart valve, repaired heart defect ________	O	O
Pacemaker or implantable defibrillator ___________	O	O
Artifical prosthesis (heart valve or joint)___________	O	O
Rheumatic or scarlet fever ___________________	O	O
High or low blood pressure ___________________	O	O
Stroke ____________________________________	O	O
Taking blood thinners _______________________	O	O
Prolonged bleeding from small cut (INR >3.5) _____	O	O
Anemia or other blood disorder ________________	O	O
Tuberculosis ________________________________	O	O
Emphysema, sarcoidosis _____________________	O	O
Asthma ____________________________________	O	O
Breathing or sleep problems (snoring, sinus) ______	O	O
Kidney disease ______________________________	O	O
Liver disease _______________________________	O	O
Jaundice ___________________________________	O	O
Thyroid, parathyroid disease or calcium deficiency _	O	O
Hormone deficiency__________________________	O	O
High cholesterol or taking statin drugs ___________	O	O
Diabetes (HbA1c = ______) ___________________	O	O
Stomach or duodenal ulcer ___________________	O	O
Digestive disorders (i.e. gastric reflux) ___________	O	O
Neurologic problems (i.e. ADD, ADHD) __________	O	O
Viral infections or cold sores __________________	O	O
Arthritis ___________________________________	O	O
Glaucoma __________________________________	O	O
Contact lenses ______________________________	O	O
Head or neck injuries ________________________	O	O
Epilepsy, convulsions, seizures ________________	O	O
Osteoporosis/osteopenia _____________________	O	O
Have taken medicine for osteoporosis (i.e. Fosamax, Boniva, etc.) ________________________________	O	O

	YES	NO
Frequent Headaches	O	O
Any lumps or swellings in the mouth _______	O	O
Hepatitis (Type _______) _______________	O	O
HIV/AIDS ____________________________	O	O
Tumor, abnormal growth ________________	O	O
Radiation therapy ______________________	O	O
Chemotherapy _________________________	O	O
Emotional problems _____________________	O	O
Psychiatric treatment ___________________	O	O
Antidepressant medication _______________	O	O
Alcohol/drug dependency _______________	O	O
Chewing tobacco/dip habit _______________	O	O
Allergic reaction to:		
Aspirin, Ibuprofen, Tylenol __________	O	O
Codeine_________________________		
Penicillin ________________________	O	O
Clindamycin ______________________	O	O
Sulpha __________________________	O	O
Fluoride_________________________	O	O
Metals (i.e. nickel, gold, ___________)	O	O
Latex ___________________________	O	O
Other (_________________________)	O	O
I HAVE NO KNOWN ALLERGIES	O	O
ARE YOU:	O	O
Presently being treated for any other illness__	O	O
Aware of a change in your general health ___	O	O
Taking dietary supplements ______________	O	O
Smoker or previous smoker ______________	O	O
FEMALE-pregnant _____________________	O	O
FEMALE-taking birth control pills __________	O	O
MALE-prostate disorders ________________	O	O

Describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment: ____
____

List all medications, supplements, and/or vitamins taken within the last two years: ________________________
____
____

I certify that the above information is complete and correct.

Patient's signature:____ Date: _______________

Doctor's signature: ____ Date:_____________