CONFIDENTIAL MEDICAL HISTORY

CONFIDENTIAL MEDICAL HISTORY FOR:_____
first name middle initial last name

Why such a detailed medical history? Remember the old "Your foot bone connected to you ankle bone, your ankle bone connected to your etc..." Well, we know now that everything medical about us seems to be connected or linked in some way.
A detailed medical history helps to keep you and everyone connected to you safe and assists in giving you the best dental care possible. Do not worry about telling us about any aspect of your medical history, no matter how remote it may seem to be connected to your teeth or mouth. All information is held in the strictest of confidentiality. This form gets scanned into your secure dental record then is destroyed.

List All Your Doctor's Names:_____

Which Pharmacy do you use:_____

Do you have any illnesses, diseases, conditions or disorders?(circle) YES NO

If YES, List or circle from list on the other side of this page. _____

_____

List all MEDICATIONS you take or better yet, give us your DRUG CARD to copy.

_____

_____

Do you SMOKE? (circle) YES NO

Do you take any blood thinners? (circle) YES NO (circle which ones or add others)

DAILY ASPIRIN PLAVIX TICLID COUMADIN AGRINOX

MORE THAN 3 ALCOHOLIC DRINKS/DAY OTHERS? _____

Do you take medications for: (circle)

BLOOD PRESSURE HEART DIABETES(SUGAR) OSTEOPOROSIS CANCER

SEIZURES / EPILEPSY IMMUNE SUPPRESSION(eg. prednisone) INFLAMMATION

Do you have any ARTIFICIAL PARTS: eg. heart valves, joint replacements: hips, knees etc.

LIST The parts and the year the surgery was performed:

_____

Do you have any ALLERGIES? (circle) YES NO If YES, please list:

_____

_____

CHECKLIST OF CONDITIONS, ILLNESSES AND DISEASES

ALLERGIES TO
Antibiotics
Aspirin/Ibuprofen/Nsaids
Codeine
Tylenol
Dermographic
Environmental
Food
Other_____
_____
_____

CARDIOVASCULAR SYSTEM (HEART)
"Weak Heart"
Problem but Unsure of Condition
High Blood Pressure
Heart Attack
High Cholesterol
CVA (Stroke)
Shortness of Breath
Pacemaker
Heart Valve Replacement/Problems
Heart Murmur

HEMATOPOIETIC SYSTEM (BLOOD)
Blood Disorders
Hemophilia
Taken Aspirin in Last 2 Weeks
Blood Transfusions
Abnormal Bleeding
Bruise Easily
Blood Thinners

ENDOCRINE SYSTEM
Diabetes
Hypothyroid
Hyperthyroid

TRANSMITTABLE DISEASES
Hepatitis A,B or C
HIV/AIDS
Genital Herpes,
Syphilis,Gonorrhea

BONES AND JOINTS
Osteoporosis
Bone Infections/
Osteomyelitis
Fractures/Breaks

DIGESTIVE SYSTEM
Ulcers
Jaundice
Colitis/Crohns Disease
Heartburn

RESPIRATORY SYSTEM
Tuberculosis
Emphysema
Asthma/Bronchitis
Sinus Problems

AUTOIMMUNE
Arthritis
Fibromyalgia
Muscular Dystrophy
Lichen Planus
Psoriasis
Eczema
Other_____
_____

NERVES
Depression
Anxiety
Seizures

OTHER ALLERGIES
Dermographic
Environmental
Food
Other_____
_____

KIDNEYS
Kidney Trouble
Transplant
Dialysis

CHILDHOOD DISEASES
list_____
_____

NEOPLASMS
Tumors or Malignancy
Cancer
Chemotherapy/Radiation
Head and Neck Radiation

REPRODUCTIVE
Pregnant
Nursing
Contraceptives
Hormonal Therapy

OTHER
Glaucoma
Contact Lenses
Drink More Than 5 Alcoholic Beverages/Day
Red Wine and Garlic Frequently
Addictions/If Yes, In Treatment or Not

Please add any other conditions, illnesses or diseases not listed above or add any notes you may feel are relevant to your medical history in the space below:

Date:_____ Signature:_____