Patient Name: _____ Chart#: _____ Team Member: _____

Medical History

Do you have or have you ever been treated for any of the following:

What is your height _____ weight_____?

□ YES □ NO HEART MURMUR
- □ Functional (Nonpathological) No Premedication
- □ Valvular Stenosis or regurgitation(Premedication)
- □ Don't know

□ YES □ NO HEART FAILURE
- □ Congestive □ Dyspnea(Labored Breathing at Rest) □ Don't know

□ YES □ NO HEART SURGERY
IF YES EXPLAIN, _____

□ YES □ NO HEART DISEASE OR ATTACK (Myocardial Infraction)

□ YES □ NO ANGINA PELTORIS

□ YES □ NO CORONARY ARTERY ATHEROSCLEROSIS

□ YES □ NO CONGENITAL HEART LEASION

□ YES □ NO MITRAL VALVE PROLAPSE*

□ YES □ NO HEART VALVE DEFECT*

□ YES □ NO HEART VALVE PROSTHETIC REPLACEMENT*

□ YES □ NO RHEUMATIC FEVER*

□ YES □ NO SCARLETT FEVER

□ YES □ NO IMPLANTED DEFIBRILLATOR

□ YES □ NO STROKE

□ YES □ NO BYPASS

□ YES □ NO PACEMAKER

□ YES □ NO ARTIFICIAL JOINT
IF YES, □ Hip □ Knee/When _____

□ YES □ NO DO YOUR ANKLES SWELL

□ YES □ NO HAVE YOU □ LOST or □ GAINED 10 POUNDS IN THE LAST YEAR

□ YES □ NO DO YOU EVER AWAKEN SHORT OF BREATH

□ YES □ NO □ HIGH or □ LOW BLOOD PRESSURE

□ YES □ NO ANY BLEEDING DISORDERS, IF YES, Explain_____

□ YES □ NO BLOOD TRANSFUSIONS, IF YES, WHAT YEAR_____WHY_____

ALLERGIC REACTION TO:

□ YES □ NO PENICILLIN
□ YES □ NO ERYTHROMYCIN
□ YES □ NO SULFA
□ YES □ NO CODEINE
□ YES □ NO ASPIRIN
□YES □ NO LATEX
□ YES □ NO FOOD ALLERGY_____
□ YES □ NO LOCAL DENTAL ANESTHETIC
□ YES □ NO BARBITUATION SEDATION OR SLEEPING PILLS
□ YES □ NO OTHER _____

PLEASE LIST ALL THE NAMES AND PHONE NUMBERS OF THE PHYSICIANS CURRENTLY PROVIDING YOU CARE.

_____
_____

DATE OF LAST PHYSICAL EXAM_____

□ YES □ NO ANEMIA
□ YES □ NO HEMOPHILIA
□ YES □ NO SICKLE CELL TRAIT/ ANEMIA
□ YES □ NO SICKLE CELL DISEASE
□ YES □ NO BRUISE EASILY
□ YES □ NO STOMACH PROBLEMS/ULCERS
□ YES □ NO COLD SORES
□ YES □ NO □ SLOW OR □ DIFFICULTY HEALING
□ YES □ NO DO YOU USE MORE THAN TWO PILLOWS TO SLEEP?(Orthopenia)
□ YES □ NO DO YOU SMOKE?
YES, HOW MUCH A DAY _____
□ YES □ NO LUNG / BREATHING PROBLEMS
□ YES □ NO ASTHMA
□ YES □ NO CHRONIC OBSTRUCTION PULMONARY DISEASE (EMPHYSEMA)
□ YES □ NO COUGH/COUGH UP BLOOD
□ YES □ NO TUBERCULOSIS
How Long?_____
□Active □ Incarcerated □ Don't know
□ YES □ NO BRONCHITIS
□ YES □ NO ARTHRITIS
□ YES □ NO SINUS TROUBLE
□ YES □ NO ARE YOU ON A SPECIAL DIET?
EXPLAIN_____
□ YES □ NO DO YOU TAKE DIET PILLS?
YES, WHAT KIND? _____
□ YES □ NO DIABETES
- □ Type 1 (Insulin Dependent)
- □ Type 2 (Non-Insulin Dependent)

□ YES □ NO THYROID PROBLEM
- □ Hyperthyroidism □ Hypothyroidism

□ YES □ NO KIDNEY PROBLEMS/DYSFUNCTION
□ YES □ NO LIVER PROBLEMS/ DYSFUNCTION
□ YES □ NO GLAUCOMA IF YES,
□ Open angle glaucoma □ Narrow angle glaucoma
□ YES □ NO HEPATITIS
□ HEP A □ HEP B □ HEP C
□ YES □ NO SORE ENLARGED LYMP NODE

□ YES □ NO HIV/AIDS
□ YES □ NO YELLOW JAUNDICE
□ YES □ NO SEXUALLY TRANS. DISEASES
□ Syphilis □ Gonorrhea □ Genital Herpes
□ Other _____
□ YES □ NO EPILEPSY OR SEIZURE
□ YES □ NO FAINTING/DIZZY SPELL
IF YES, DUE TO:
□ Chronic postural orthostatic hypotic
□ Symptomatic hypotic □ Transit Ischemic Attack
□ Don't know
□ YES □ NO HEARING DISABILITY
□ YES □ NO NERVOUSNESS
□ YES □ NO MENTAL DISORDER
□ YES □ NO PSYCHIATRIC TREATMENT
□ YES □ NO ALCOHOLISM
□ YES □ NO DRUG ABUSE /ADDICTION
□ YES □ NO CANCER / TUMOR
□ YES □ NO OTHER GROWTHS_____
□ YES □ NO CHEMOTHERAPY
□ YES □ NO RADIATION THERAPY
□ YES □ NO RHEUMATISM
□ YES □ NO ALLERGY OR HIVES?
IF YES, FROM WHAT? _____
□ YES □ NO CORTIZONE MEDICINE
□ YES □ NO CLEFT LIP/PALATE
□ YES □ NO DEVELOPMENTAL DISABILITY
□ YES □ NO CEREBRAL PALSY
□ YES □ NO MENTAL REATARDATION
□ YES □ NO HEARING DISABILITY

WOMEN

□ YES □ NO ARE YOU PREGNANT?
□ YES □ NO DO YOU ANTICIPATE BECOMING PREGNANT?
□ YES □ NO IS THERE ANY CHANCE THAT YOU ARE PREGNANT?
□ YES □ NO ARE YOU NURSING?

□ YES □ NO DO YOU NEED TO BE PREMEDICATED WITH ANTIBIOTICS PRIOR TO YOUR DENTAL APPOINTMENTS?

□ YES □ NO WHEN YOU WALK UP STAIRS OR TAKE A WALK, DO YOU EVER HAVE TO STOP BECAUSE OF PAIN IN YOUR CHEST, SHORTNESS OF BREATH, OR EXTREME FATIGUE?

□ YES □ NO HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL APPOINTMENTS? YES, EXPLAIN _____

□ YES □ NO HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS SURGERY (EX: EXTRACTION OR ACCIDENTS)? YES, EXPLAIN: _____

□ YES □ NO HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS
YES, EXPLAIN: _____

ARE YOU TAKING ANY OF THE FOLLOWING? IF YES, PLEASE LIST IN THE SPACE PROVIDED
□ ANTIBIOTIC _____ □ ASPIRIN _____ □ SULFA DRUG _____
□ TRANQUILIZERS _____ □ ANTICOAGNANT (BLOOD THINNERS) _____
□ CORTISOR OR STEROIDS _____ □ BLOOD PRESSURE MEDS. _____
□ DIFANTIN OR OTHER ANTICONVULSANT _____ □ INSULIN, TOLBUTAMIDE, ORINAZOR, OR SIMILAR DRUG _____ □ GRAPEFRUIT EXTRACT/ JUICE □ TAGAMET (CINETIDINE) □ FOSAMAX □ ACTONEL □ BONIVA □ AREDIA □ ZOMETA □ OTHER MEDICATIONS TAKEN: _____

□ YES □ NO DO YOU HAVE ANY CONDITION OR PROBLEM NOT LISTED HERE?
IF YES, EXPLAIN _____

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPRECTIVE HEALTHCARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH AND/OR MEDICATION.

PATIENT/GUARDIAN SIGNATURE:_____DENTIST SIGNATURE_____DATE:_____

ASA	MALLAMPATI	CURRENT MEDICAL PROBLEM	CURRENT MEDICATION	HEIGHT WEIGHT
I.	I.			BLOOD PRESSURE
II.	II.			RESP RATE
III.	II.			PULSE
IV.	IV.			SpO2%
ALLERGIES				TEMPATURE