Patient Name_____DOB_____

BRASS CITY DENTISTRY

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If yes, please explain: _____

Have you been hospitalized or visited the emergency room in the last 6 months? ☐Yes ☐No If yes, what were you treated for?_____

_____

Are you currently taking blood thinners? ☐Yes ☐No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No If yes, please explain: _____

Have you or anyone in your family had any complications with general anesthesia? ☐Yes ☐No

Please list any and all allergies:

_____

_____

Habits - Amounts

☐ Smoke _____Packs ☐ Alcohol _____ Per Day

☐ Drug Use _____ Have you ever had a problem with drugs or alcohol? ☐Yes ☐No

Other _____

Please list all medications you are now taking:

Medication	**Dosage**	**Why**

Y /N (Please Check)

GENERAL
- ☐☐ Tire Easily, Weakness
- ☐☐ Marked Weight Change
- ☐☐ Persistent Fever
- ☐☐ Taken Steroids
- ☐☐ Bruise easily
- ☐☐ Frequent Headaches

SKIN
- ☐☐ Changes in Skin Color
- ☐☐ Rashes, Hives
- ☐☐ Shingles

EYES
- ☐☐ Eye Problems
- ☐☐ Glaucoma

EARS
- ☐☐ Loss of Hearing
- ☐☐ Ear Infections

NOSE
- ☐☐ Sinus Problems
- ☐☐ Frequent Nose Bleeds

Y /N (Please Check)

THROAT
- ☐☐ Frequent Sore Throat
- ☐☐ Post Nasal Drip
- ☐☐ Cleft Palate

ENDOCRINE
- ☐☐ Diabetes
- ☐☐ Thyroid Problems
- ☐☐ Other Gland Problems
- ☐☐ Hypoglycemia

NERVOUS SYSTEM
- ☐☐ Stroke
- ☐☐ Frequent Headaches
- ☐☐ Convulsions/Epilepsy
- ☐☐ Numbness/Tingling
- ☐☐ Dizziness/Fainting
- ☐☐ Nerve Problems
- ☐☐ Head Injury
- ☐☐ Psychiatric Treatment
- ☐☐ Emotional Problems

Y /N (Please Check)

CARDIOVASCULAR
- ☐☐ Mitral Valve Prolapse
- ☐☐ Rheumatic Fever
- ☐☐ Any Heart Disease
- ☐☐ High Blood Pressure
- ☐☐ Low Blood Pressure
- ☐☐ Chest Pain/Discomfort
- ☐☐ Congenital Heart Disease
- ☐☐ Artificial Heart Disease
- ☐☐ Pacemaker
- ☐☐ Scarlet Fever
- ☐☐ Heart Surgery
- ☐☐ Heart Attack
- ☐☐ Heart Murmur
- ☐☐ Irregular Heartbeat

RESPIRATORY
- ☐☐ Asthma
- ☐☐ Emphysema
- ☐☐ Bronchitis
- ☐☐ Pneumonia
- ☐☐ Persistent Cough

Y /N (Please Check)

MUSCULOSKELETAL
- ☐☐ Arthritis/Rheumatism
- ☐☐ Broken Bones
- ☐☐ Artificial Joints
- ☐☐ Osteoporosis

DIGESTIVE
- ☐☐ Changes in Appetite
- ☐☐ Black, Bloody or Pale Stools
- ☐☐ Jaundice
- ☐☐ Hepatitis
- ☐☐ Stomach Ulcers/Disease
- ☐☐ Liver Disease
- ☐☐ Intestinal Disease

URINARY
- ☐☐ Kidney Disease
- ☐☐ Kidney Transplant
- ☐☐ Venereal Disease
- ☐☐ Renal Dialysis

BLOOD
- ☐☐ Bleeding Problems
- ☐☐ Blood Disorder
- ☐☐ Sickle Cell
- ☐☐ Anemia
- ☐☐ HIV
- ☐☐ Blood Transfusion
- ☐☐ Hepatitis

If you marked *yes* to **diabetes**, do you have Type 1 ☐ or Type 2 ☐
Have you checked your blood sugar today? Yes ☐ or No ☐ Indicate your most recent blood sugar reading_____
Indicate your most recent A1C reading_____

If you marked *yes* to **asthma**, is your asthma controlled? Yes ☐ or No ☐

Continued:

Y /N (Please Check)

DEVELOPMENTAL

- ☐☐ Autism
- ☐☐ ADHD
- ☐☐ Disabilities/ Special Needs
- ☐☐ Down Syndrome
- ☐☐ Spina Bifida

Y /N (Please Check)

OTHER

- ☐☐ Auto-Immune Disorders
- ☐☐ Radiation Treatment
- ☐☐ Tumors/Growths
- ☐☐ Cancer
- ☐☐ Tuberculosis

All Operations or Surgeries: Year

_____
_____
_____
_____

Is there anything else you feel we should know about?

_____
_____
_____
_____

WOMEN ONLY: Are You

Pregnant/Trying to get Pregnant? ☐Yes ☐No *Taking oral contraceptives?* ☐Yes ☐No *Nursing?* ☐Yes ☐No

IMPORTANT: Antibiotics (Penicillin, Erythromycin, etc.) which may be prescribed after treatments, may cause the birth control pill to be ineffective. Other methods of contraception are recommended for the duration of the effected cycle.

I certify that I can speak, read, and write English and have read and fully understand this medical history form. To the best of my knowledge all the preceding answers are true and correct:

Patient/Parent/ Guardian Signature_____ Date_____

Provider Signature_____ Date_____

Provider SIgnature_____ Date_____