Springwater dental

MEDICAL HEALTH HISTORY

Name: ____ Date of Birth: ______________

Please answer the following questions to the best of your ability. True and accurate answers are important to the delivery of safe and effective care. All information will be kept confidential.

1. How would you describe your general health? EXCELLENT GOOD FAIR POOR
2. Has there been any change in you general health in the past year? YES NO
3. Are you currently under a physician's care? YES NO
4. My last physical exam was on (approximate date): __________ My Physician's Name & Phone Number: ________________________________
5. Have you had any serious illnesses, surgeries, or hospitalizations in the past 5 years? YES NO

   If YES, please describe: ____

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

HEAD

Yes / No Glaucoma
Yes / No Sinus Problems
Yes / No Stroke/TIA
Yes / No Seizures/Epilepsy
Yes / No Fainting/Dizziness
Yes / No Parkinson's
Yes / No Cerebral Palsy
Yes / No Depression
Yes / No Developmental Delay
Yes / No Autism
Yes / No Dementia
Yes / No Alzheimer's
Other: ____________________

HEART

Yes / No High Blood Pressure
Yes / No Low Blood Pressure
Yes / No Congestive Heart Failure
Yes / No Congenital Heart Disease
Yes / No Heart Murmurs
Yes / No Rheumatic Fever
Yes / No Valve Replacement
Yes / No Chest Pain/Angina
Yes / No Heart Attack
Yes / No Arrhythmia
Yes / No Pacemaker/Defibrillator
Other: ____________________

LUNGS

Yes / No Asthma
Yes / No Bronchitis
Yes / No Emphysema
Yes / No Pulmonary Fibrosis
Yes / No Chronic Cough
Yes / No Pneumonia
Yes / No Tuberculosis
Other: ____________________

BLEEDING DISORDERS

Yes / No Bruise Easily
Yes / No Hemophilia
Yes / No Anemia
Yes / No Anticoagulant Therapy
Other: ____________________

LIVER/KIDNEYS

Yes / No Hepatitis
Yes / No Cirrhosis
Yes / No Dialysis
Yes / No Renal Failure
Other: ____________________

DIGESTIVE SYSTEM

Yes / No Special/Restricted Diet
Yes / No Ulcers
Yes / No GI Bleeding
Yes / No Gastric Reflux/GERD
Yes / No Colitis/Crohn's/IBS
Other:
____

HORMONES/IMMUNE SYS.

Yes / No Hyperthyroidism
Yes / No Hypothyroidism
Yes / No Diabetes
Yes / No Lupus
Yes / No HIV+
Yes / No Steroid Therapy
Yes / No Recurring infections
Other: ____________________

MUSCLE/SKELETON

Yes / No Artificial Joint(s)
Yes / No Arthritis
Yes / No Multiple Sclerosis
Yes / No Osteoporosis
Other: ____________________

OTHER

Yes / No Cancer
Yes / No Radiation Therapy
Yes / No Organ Transplant
Yes / No Tobacco
Yes / No Alcohol
Yes / No Recreational Drugs

WOMEN

Yes / No Birth Control
Yes / No Pregnant
Yes / No Trying to get pregnant
Yes / No Breast Feeding

Antibiotics may reduce the effectiveness of birth control pills; alternate methods of birth control are recommended during antibiotic therapy.

PLEASE USE THIS SPACE TO DESCRIBE ANY CONDITION NOT LISTED OR IF YOU HAVE ANY SPECIFIC MEDICAL CONCERNS:

LIST ALL CURRENT MEDICATIONS (INCLUDING SUPPLEMENTS), DOSAGES, AND FREQUENCY:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

ARE YOU TAKING OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS (please circle):

Aredia Zometa Actonel Boniva Fosamax Didronel Skelid Bisphosphonates None

DO YOU HAVE ANY ALLERGIES THAT YOU ARE AWARE OF? YES NO

If **YES**, please list and describe: ____

Any questions regarding this form have been answered to my satisfaction. To the best of my knowledge, the information is complete and accurate.

Patient (Guardian) Signature: Date: