PARADISE
DENTAL PROFESSIONALS

MEDICAL HISTORY

Patient's Name _____

Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name _____
   Address _____
   Phone _____
2. Are you under a physician's care? .....YES NO
   Since when? _____ Why? _____
3. When was your last complete physical exam? _____
4. Are you taking any medications or substances? ..... YES NO
   If yes, please list medications or substances on the back of this form.
5. Do you routinely take health related substances? (vitamins, supplements)..... YES NO
6. Are you allergic to any medications or substances? ..... YES NO
   Please list _____
7. Do you have any other allergies or hives? .....YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?
   YES NO If yes, please explain _____
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Have you ever been treated for or been told you might have heart disease? ..... YES NO
12. Do you have a pacemaker? ..... YES NO
    Artificial heart valve implant? ..... YES NO
    Mitral valve prolapse? ..... YES NO
13. Have you ever had rheumatic fever? .....YES NO
14. Are you aware of any heart murmur? ..... YES NO
15. Do you have high or low blood pressure? ..... YES NO
    If yes, which? _____
16. Have you ever had a serious illness or surgery? ..... YES NO
    If yes, please explain _____
17. Have you ever had radiation treatment or chemotherapy? ..... YES NO
    If yes, please explain _____
18. Have you ever taken Fosamax or any other bisphosphonates for osteoporosis? ..... YES NO
19. Do you have inflammatory diseases such as arthritis or rheumatism? ..... YES NO
20. Do you have any artificial joints/prosthesis? .....YES NO

21. Do you have any blood disorders such as anemia, leukemia, hemophilia, etc.? ……YES NO
    If yes, please explain _____
22. Do you have any of the following conditions:
    Excessive bleeding …… YES NO
    Stomach problems …….. YES NO
    Liver problems …… YES NO
    Diabetic …….. YES NO
    Fanting/dizziness …….. YES NO
    Asthma …… YES NO
    Epilepsy or seizures …… YES NO
23. Do you or have you had any sexually transmitted disease? …… YES NO
24. Have you tested HIV positive? ……. YES NO Have you tested positive for AIDS? …… YES NO
25. Have you had or do you test positive for hepatitis? ……..YES NO
26. Do you have or have you had TB? …….. YES NO
27. Do you use tobacco? …….. YES NO
28. Do you regularly consume more than one or two alcoholic beverages per day? …… YES NO
29. Do you habitually use controlled substances? …….. YES NO
30. Have you had psychiatric treatment? …….. YES NO
31. Have you taken prescription drugs for weight loss? …….. YES NO
32. Do you have any disease or condition not listed? …….. YES NO
    If yes, please explain _____
33. Is there anything else we should know about your health or history that is not on this form that we should know? Please explain _____
    _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARDIAN'S SIGNATURE _____DATE _____

DENTIST'S SIGNATURE _____ DATE _____

COMMENTS/NOTES

_____

_____

_____

_____

_____