**Medical History Form**

**Darrin J. Violi, DMD**

**FULL NAME**_____**TELEPHONE #** (_____)_____

**Date of birth**_____/_____/_____ **Age:** _____ **Sex:**_____ **Height:** _____ft._____in. **Weight**:_____lbs.

**What is your chief complaint (reason for visit?**_____

**Please circle Yes or No:**

Has there been any change in your health within the last year?..... **yes** **no**

If yes, please explain: _____

Are you now under the care of a physician? …… **yes** **no**

If yes, please explain:_____

Have you had any serious illness or operation? …… **yes** **no**

If yes, please explain:_____

Have you been hospitalized in the past five years? …… **yes** **no**

If yes, please explain:_____

Do you have, or have you ever had, ***heart problems***? …… **yes** **no**

*(Circle if applies)* Rheumatic fever, Rheumatic heart disease, congenital heart defect or problems
Heart attack/Myocardial infarction, High blood pressure/Hypertension, Chest pain/Angina, Shortness of breath, Irregular heartbeat, Rapid heartbeat, Pacemaker, Swollen ankles, Arteriosclerosis, Heart murmur, Valve problems/Artificial valve replacement.

Coronary Artery Bypass Graft (CABG) (*when*)_____

Do you have any ***implanted man-made materials*** (knee, hip, shoulder, pacemaker, artificial heart valves, etc.)? **yes** **no**

Have you ever had to be ***pre-medicated with an antibiotic*** prior to dental surgery? **yes** **no**

If yes, please list why (Infection, Heart murmur, Valve replacement, etc.)_____

**(If yes, YOU MUST inform the doctor before any procedures are performed!)**

Do you have, or have had, ***lung problems***? …… **yes** **no**

*(Circle if applies)* Asthma, Bronchitis, Tuberculosis, Emphysema

Other lung problems? Please explain:_____

Do you smoke cigarettes or cigars? …… **yes** **no**

If yes, which one and how much?_____

Do you have, or have you had, ***liver problems?*** …… **yes** **no**

(*Circle if applies*) Hepatitis A, B, or C, Yellow Jaundice

Other liver problems? Please explain:_____

Do you drink alcoholic beverages? …… **yes** **no**

If yes, how much and how often?_____

Do you have, or have you had, ***kidney problems***? …… **yes** **no**

(*Circle if applies*) Frequent kidney infections, frequent urinary tract infections, blood in the urine

Other kidney problems? Please explain:_____

Do you have, or have you had, ***blood problems?*** …… **yes** **no**

(*Circle if applies*) Anemia, bleeding problems, bruise easily, blood transfusion

Other blood problems? Please explain:_____

Have you had abnormal bleeding or any problems associated with previous tooth removal or oral surgery? …. **yes** **no**

Have you ever been told you have ***Angioedema***? …… **yes** **no**

If yes, what type?_____

Do you have, or have you had, ***stomach or intestinal problems***? …… **yes** **no**

(*Circle if applies*) Ulcers, Blood in stool or black stools, Vomiting blood

Other stomach or intestinal problems? Please explain: _____

Are you taking, or have you ever taken ***Bisphosphonates*** for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Didronel, Skelid)? …… **yes** **no**

Do you have, or have you had, any of the following:

| | | |
|---|---|---|
| Sinus trouble, Seasonal allergies, Hay fever…… | **yes** | **no** |
| Skin rashes…… | **yes** | **no** |
| Fainting spells…… | **yes** | **no** |
| Seizures or Epilepsy…… | **yes** | **no** |
| A serious viral illness…… | **yes** | **no** |
| Hypoglycemia or low blood sugar…… | **yes** | **no** |
| Diabetes or high blood sugar…… | **yes** | **no** |

Arthritis or inflammatory rheumatism…… **yes no**
Persistent cough or cough up blood…… **yes no**
Sexually transmitted diseases…… **yes no**
If yes, when were you treated?_____
Auto-immune disadvantage or disorder…… **yes no**
Cancer…… **yes no**
If yes, where and what type_____
Chemotherapy or Radiation Therapy…… **yes no**
Stroke …… **yes no**
If yes, when_____
Hypothyroidism…… **yes no**
Hyperthyroidism…… **yes no**
Do you use ***chewing tobacco or smokeless tobacco***…… **yes no**
If yes, how often?_____

Please list any other diseases, illnesses or health problems not covered above:_____

_____

Please list ***ALL*** medications you are ***currently taking***, including over-the-counter medications, herbs and vitamins, and prescriptions. Please include dosages:_____

_____

List all medications that you have ***previously taken*** within the past month but are not taking now: _____

_____

List all surgeries, X-rays, or radiation treatment for a ***tumor, growth, or other condition***: _____

_____

Are you ***allergic*** to or have you ***had a bad reaction to*** any of the following drugs?

| | | | |
|---|---|---|---|
| Local/topical anesthetic…… | **yes no** | Tylenol #3…… | **yes no** |
| General anesthesia…… | **yes no** | Vicodin…… | **yes no** |
| Aspirin…… | **yes no** | Codeine…… | **yes no** |
| Iodine…… | **yes no** | Other narcotic (_____ ) | **yes no** |
| Sulfa drugs…… | **yes no** | Other antibiotic (_____) | **yes no** |
| Penicillin…… | **yes no** | Steroids/Solu-Cortef/Decadron.. | **yes no** |
| Benadryl…… | **yes no** | Compazine…… | **yes no** |
| Phenergan…… | **yes no** | Ultram…… | **yes no** |
| Clindamycin/Cleocin…… | **yes no** | Pain medication (_____) | **yes no** |
| Ibuprofen/Advil…… | **yes no** | Barbiturates or sleeping pills…… | **yes no** |
| Latex products…… | **yes no** | Valium/ Demerol/Brevital…… | **yes no** |
| Morphine…… | **yes no** | | |

Please list any/all ***allergies*** medicines/drugs and/or foods and ***reaction caused***:_____

_____

**Women:** Are you or might you be ***pregnant***? …… **yes no**
If no, (*circle one)* have you had a tubal ligation, hysterectomy, or are you post-menopausal?
Are you trying to get pregnant? …… **yes no**
If yes, please list the first day of your last menstrual period:_____

**Current Pharmacy:**_____ **Location:**_____ **Phone#**_____

**Family Dentist Name:**_____ **Location:**_____ **Phone#**_____

**Primary Physician Name:**_____ **Location:**_____ **Phone#**_____

By signing this form, I agree I have read and understood the above. I understand it is my responsibility to fill out the form correctly and completely.

_____ _____

***Signature of patient, parent or guardian (if under 18)*** ***Date***

**FOR COMPLETION BY THE DOCTOR**

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

**Date:** **Doctor's Signature:**

**Medical History Update**

| Date | Comments | Signature |
| --- | --- | --- |
| | | |
| | | |