Barnstable Dental Associates

Medical History

Patient name:_____ **Date:**_____

Your current physical health is: Good Fair Poor
Do you have a physician? Yes No
Physician's name:_____
Physician's phone number:_____
Date of last visit:_____
Do you smoke or use tobacco in any other form? Y N
Do you use any over-the-counter medications or supplements?
Y N List:_____
_____
Do you take any prescription medications? Y N Please List:
_____
_____
Do you make all decisions regarding your own healthcare? Y N
Do you have a legal guardian? Y N

Answer "yes" or "no" to all of the following:
Do you have or have you ever had…?

Y N Heart Murmur, Mitral Valve Prolapse, Aortic Stenosis
Y N Artificial Heart Valve/Valve Transplant
Y N Congenital Heart Defect
Y N Rheumatic Fever / Scarlet Fever
Y N Bacterial Endocarditis
Y N Artificial Joint Replacement
Y N Systemic Pulmonary Shunt (Dialysis)
Y N Heart Attack
Y N Pacemaker / Defibrillator
Y N High Blood Pressure (Office use only BP_____)
Y N Angina
Y N Stroke
Y N Glaucoma
Y N Do you take anything that purposely or as a side effect, suppresses your immune system? Chemo? Prednisone? Methotrexate?
Y N Do you take: Antidepressants, Blood Pressure Medications, Beta-Blockers, Digitalis, Indomethacin, MAO Inhibitors, Coumadin, Plavix, Aspirin or other Blood Thinner? Please circle above.
Y N Have you ever taken or been given Zometa, Aredia, Fosamax, Actonel, Boniva or other meds for osteoporosis or to strengthen bones after cancer treatment? Type_____ When_____

FOR WOMEN ONLY:

Y N Are you pregnant? Due date?_____
Y N Are you nursing?
Y N Do you take oral contraceptives, hormone replacement therapy, or receive hormone or contraceptive injections?

Answer "yes" or "no" to all of the following:
Do you have or have you ever had…?

Y N Abnormal Bleeding / Bruising
Y N Alcohol / Drug Dependency
Y N Anemia
Y N Arthritis
Y N Autoimmune Disorder_____
Y N Blood Transfusion
Y N Cancer_____
  Y N Chemotherapy
  Y N Radiation Treatment
Y N Colitis/ Intestinal or Colon Problems
Y N Diabetes
Y N Asthma/ Difficulty Breathing/ Respiratory Problems
Y N Emphysema
Y N Epilepsy / Seizures
Y N Fainting
Y N Heart Surgery
Y N Hemophilia Type_____
Y N Hepatitis Type: _____
Y N Herpes, Cold Sores or Fever Blisters
Y N HIV+ / AIDS
Y N Kidney Problems/ Dialysis
Y N Liver Disease / Jaundice
Y N Low Blood Pressure
Y N Memory Loss
Y N Osteoporosis
Y N Psychiatric Problems (Depression, Alzheimer's etc)
Y N Sexually Transmitted Diseases
Y N Sinus Problems
Y N Thyroid Problems
Y N Tuberculosis
Y N Gastric Ulcers
Y N Other:_____
Y N Surgeries_____

Have you ever had the following allergies?

Y N Aspirin
Y N Codeine or other '-codones'
Y N Dental Anesthetics
Y N Erythromycin or other '-mycins'
Y N Penicillin or other '-cillins'
Y N Tetracycline or other '-cyclines'
Y N Latex
Y N Nickel or other metals, Jewelry
Y N Sulfides/ Sulfates(ie. preservative in wine)
Y N Sulfa drugs
Y N Dye
Y N Other (including meds and foods):_____
_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence. I understand that it is my responsibility to inform Barnstable Dental Associates of any changes to the above information.

_____ Reviewed by:_____
Patient Signature Date Provider Signature Date