Website Patient Medical History

Please answer all questions. Answers to the following questions are for our records only and will be considered confidential.

Are you in good health? Yes ○ No ○

Height _____ **Weight** _____

Has there been any change in your general health? Yes ○ No ○

Your last physical examination was on _____

Are you now under the care of a physician? Yes ○ No ○

Name and address of your physician _____

_____

Have you ever had a serious illness or operation? Yes ○ No ○

Have you been hospitalized with any of the following within the last 5 years? Yes ○ No ○

- **Low/High blood pressure(circle one)** Yes ○ No ○
- **Did you have a persistent cough or cough up blood?** Yes ○ No ○
- **Venereal Disease** Yes ○ No ○
- **AIDS or HIV** Yes ○ No ○
- **Other**

_____

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes ○ No ○

- **Do you bruise easily?** Yes ○ No ○
- **Have you ever required a blood transfusion** Yes ○ No ○
- **If yes, explain the circumstances**

_____

Do you have any blood disorder such as anemia? Yes ○ No ○

Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips? Yes ○ No ○

Medications

Are you taking any drug or medication? Yes ○ No ○

- **If yes, what?** _____

Are you taking any of the following?

- **Antibiotics or sulfa drugs** Yes No
- **Anticoagulants (blood thinners such as Coumadin, Plavix etc)** Yes No
- **Medicine for high blood pressure** Yes No
- **Cortisone (steroids)** Yes No
- **Tranquilizers** Yes No
- **Aspirin** Yes No
- **Insulin, Tolbutamide (Orinase) or similar drug** Yes No
- **Digitalis or drugs for heart trouble** Yes No
- **Nitroglycerin** Yes No
- **Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramine), and Redux (dexfenfluramine)** Yes No
- **Oral Contraceptives** Yes No
- **If yes, what are you using?** _____
- **Chemotherapy Drugs** Yes No
- **Osteoporosis Drugs (Fosamax, Aredia, Zometa etc.)** Yes No
- **Any natural product, herbal supplement or homeopathic remedy?** Yes No
- **Other** _____

Habits

Do you smoke? Yes No

- **If yes, how much?** _____

Do you drink alcoholic beverages? Yes No

Do you take any recreational drugs? Yes No

Do you have any of the following?

Cardiac pacemaker Yes No

Implants/Artificial prosthesis (Knee joints, elbow pins etc) Yes No

A removable dental appliance Yes No

Do you have, or have you had, any of the following diseases or problems?

- Rheumatic fever or rheumatic heart disease	Yes ○ No ○
- Heart Murmur or mitral valve prolapse	Yes ○ No ○
- Congenital heart lesions	Yes ○ No ○
- Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)	Yes ○ No ○
• Do you have pain in the chest upon exertion?	Yes ○ No ○
• Are you ever short of breath after mild exercise?	Yes ○ No ○
• Do you get short of breath when you lie down or do you require extra pillows when you sleep?	Yes ○ No ○
- Hepatitis, jaundice, or liver disease	Yes ○ No ○
- Convulsions/epilepsy	Yes ○ No ○
- Stroke	Yes ○ No ○
- Asthma or hay fever	Yes ○ No ○
- Hives or skin rash	Yes ○ No ○
- Fainting spells or seizures	Yes ○ No ○
- Diabetes	Yes ○ No ○
• Do you have to urinate (pass water) more than six (6) times a day?	Yes ○ No ○
• Are you thirsty much of the time?	Yes ○ No ○
• Does your mouth frequently become dry?	Yes ○ No ○
- Arthritis	Yes ○ No ○
- Inflammatory rheumatism (painful, swollen joints)	Yes ○ No ○
- Stomach ulcers	Yes ○ No ○
- Kidney trouble	Yes ○ No ○
- Tuberculosis	Yes ○ No ○
- Are you immunosuppressed? Possibly from transplant surgery	Yes ○ No ○
- A tumor or growth	Yes ○ No ○
- Radiation therapy or chemotherapy	Yes ○ No ○
- Thyroid trouble	Yes ○ No ○
- Bleeding tendency /abnormal bleeding	Yes ○ No ○