MEDICAL HISTORY

DATE _____ REFERRED BY _____

FIRST _____ MI _____ LAST _____ PHYSICIAN NAME _____

ADDRESS _____ PH _____ FORMER DENTIST _____

CITY _____ ST _____ ZIP _____ EMER CONTACT NAME/# _____

EMPLOYER _____ PH _____ _____

DRIVER'S LICENSE NO. _____ DENTAL INSURANCE:

SOCIAL SECURITY NO. _____ 1. _____

BIRTHDATE _____ SEX: ☐ M ☐ F 2. _____

MARITAL STATUS. _____ SPOUSE _____ RESPONSIBLE PARTY _____

PARENT OR GUARDIAN (IF UNDER 18) _____ REASON FOR DENTAL VISIT _____

E-MAIL ADDRESS _____ _____

HAVE YOU EVER HAD OR HAVE:

1. Are you in good health? …… YES NO
2. Have you ever had a joint replacement? YES NO
3. Have you ever been told you need to pre-medicate with antibiotics prior to dental treatment? YES NO
4. Has there been any change in your general health within the past year? …… YES NO
5. My last physical examination was on _____
6. Are you now under the care of a physician? …… YES NO
   If yes, what is the condition being treated? _____
7. Have you had any serious illness or operation? …… YES NO
   If so, what was the illness or operation? _____
8. Have you been hospitalized or had a serious illness within the past five (5) years? …… YES NO
   If so, what was the problem? _____
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves …… YES NO
   b. Congenital heart lesions …… YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke… YES NO
      1) Do you have pain in chest upon exertion? …… YES NO
      2) Are you ever short of breath after mild exercise? …… YES NO
      3) Do your ankles swell? …… YES NO
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? YES NO
      5) Do you have a cardiac pacemaker? …… YES NO
   d. Allergy …… YES NO
   e. Sinus trouble …… YES NO
   f. Asthma or hay fever …… YES NO
   g. Hives or skin rash …… YES NO
   h. Fainting spells or seizures …… YES NO
   i. Diabetes …… YES NO
   j. Hepatitis, jaundice or liver disease?…… YES NO
   k. Arthritis …… YES NO
   l. Inflammatory rheumatism (painful swollen joints) …… YES NO
   m. Stomach ulcers …… YES NO
   n. Kidney trouble …… YES NO
   o. Tuberculosis …… YES NO
   p. Do you have a persistent cough or cough up blood?…… YES NO
   q. Low blood pressure …… YES NO
   r. Venereal disease …… YES NO
   s. Acquired Immune Deficiency Syndrome (AIDS) or HIV…… YES NO
   t. Other _____
10. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? …… YES NO
    a. Do you bruise easily …… YES NO
    b. Have you ever required a blood transfusion? …… YES NO

(OVER)

If so, explain the circumstances _____

_____

11. Do you have any blood disorder such as anemia? …… YES NO
12. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? …….…..... YES NO
13. Are you taking any drugs or medications? ……..…... YES NO
    If so, what? _____
14. Are you taking any of the following?
    a. Antibiotics or sulfa drugs …….. YES NO
    b. Anticoagulants (blood thinners) …… YES NO
    c. Medicine for high blood pressure …… YES NO
    d. Cortisone (steroids) ……... YES NO
    e. Tranquilizers …….. YES NO
    f. Antihistamines ……YES NO
    g. Aspirin ……... YES NO
    h. Insulin, tolbutamide (Orinase) or similar drug …….. YES NO
    i. Digitalis or drugs for heart trouble …… YES NO
    j. Nitroglycerin …….. YES NO
    k. Oral contraceptive or other hormonal therapy …….. YES NO
    l. Other _____
15. Are you allergic or have you reacted adversely to:
    a. Local anesthetics …… YES NO
    b. Penicillin or other antibiotics ……YES NO
    c. Sulfa drugs …… YES NO
    d. Barbiturates, sedatives or sleeping pills …… YES NO
    e. Aspirin ……..…… YES NO
    f. Iodine ……..……... YES NO
    g. Codeine or other narcotics ……..…….. YES NO
    h. Other _____
16. Have you ever had or have problems with your jaw? (pop, click, pain, difficulty opening or closing)…… YES NO
17. Do you have any problems with snoring? ..... YES NO
18. Have you ever been diagnosed with sleep apnea? ……..... YES NO
19. Have you ever taken any drugs for osteoporosis to prevent bone loss (ex: Fosamax, Boniva, Actonel, Prolia) or for Paget's Disease (Didronel, Skelid) or any IV bisphosphonates for the treatment of cancer-related conditions (ex: Aredia, Zometa)? How long? _____..... YES NO
20. Have you had any serious trouble associated with any previous dental treatment? …… YES NO
    If so, explain _____
21. Do you have any disease, condition, or problem not listed above that you think I should know about? ……. YES NO
    If so, explain _____
22. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? …… YES NO

WOMEN

23. Are you pregnant? …… YES NO
24. Are you nursing? ……... YES NO

I have received and read the NOTICE OF HIPPA PRIVACY PRACTICES as required by law from the office of Drs. Marci & Glenn Beck.

_____ PATIENT SIGNATURE

_____ _____ _____

Patient Initials Date DENTIST SIGNATURE