



## MEDICAL HISTORY

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient Name: \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person?

Your Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Dental History

Have you ever had a root canal treatment before?  Yes  No

If so, has the tooth we are evaluating today had root canal treatment?  Yes  No

Have you had any recent dental treatment on the tooth we are evaluating today?  Yes  No

If so, please describe: \_\_\_\_\_

Briefly describe your symptoms: \_\_\_\_\_

### Medical History

Are you presently taking any medications/drugs/pills?  Yes  No

Have you or anyone in your family had an adverse reaction to local anesthesia, IV sedation, or general anesthesia?  Yes  No

Is there anything you would like to discuss privately with the Dentist?  Yes  No

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**Medications**

List prescriptions (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances. Include dosages if available.


**Medications**

Are you allergic/ sensitive (or ever had an adverse reaction) to: Check all that apply or check none

- Penicillin   
  Local Anesthetic   
  Codeine   
  Metals   
  Latex  
 Aspirin   
  Other Antibiotics   
  None   
  Other Medications or Substances: \_\_\_\_\_

**Bisphosphonates**

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibrandronate (Boniva®) for osteoporosis or Paget’s disease?

- Yes     No

Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget’s disease, multiple myeloma or metastatic cancer?

- Date treatment began:                       Yes     No

**Comments**

Are you required to premedicate prior to dental treatment?                       Yes     No

Have you had any other serious illness, hospitalization or accident?                       Yes     No

If yes, please explain: \_\_\_\_\_

**WOMEN: Are you pregnant or suspect that you may be?**                       Yes     No

Are you nursing?     Yes     No

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**Do you have, or have you ever had any of the following: (YES OR NO)**

- |  |  |   |  |
|--|--|---|--|
| 1. Artificial (prosthetic heart valve)   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Blood Disorders   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Previous infective endocarditis       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Anemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Damaged valves in transplanted heart  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Leukemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Congenital heart disease (CHD)        |  | 32. Prolonged Bleeding  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Unrepaired, cyanotic CHD               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Hemophilia  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Repaired (completely) in last 6 months | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Sickle Cell Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Repaired CHD with residual defects     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Heart Disease/Surgery                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Tumors  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Heart murmur                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Heart pacemaker                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Radiation Therapy   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Rheumatic fever/heart disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Neurological Disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Mitral valve prolapse                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Epilepsy  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. High/low blood pressure              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Stroke  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Learning Disability                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Arthritis / Rheumatism  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Mental Health Disorder               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Autoimmune Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Anorexia                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Artificial Joint / Prosthesis   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Bulimia                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Liver Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Lung disease/COPD                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. Hepatitis (select one)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Tuberculosis                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other |  |
| 17. Asthma                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Ulcers  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Shortness of Breath                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Gastrointestinal Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Respiratory Ailments                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 49. GERD (gastric reflux)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Emphysema                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 50. Deaf or Hard of Hearing   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Sinus Trouble                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 51. Glaucoma  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Diabetes Type I or Type II           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 52. Cortisone Medication  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Thyroid Problems                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 53. Fainting Spells   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Persistent swollen glands            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 54. Organ Transplant  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Kidney Problems                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 55. Removal of Spleen   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Venereal Disease                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 56. Osteoporosis  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. HIV Positive/AIDS/ARC                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 57. Sleep Disorder  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28. Alcohol/Drug Addiction               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 58. Elevated Cholesterol  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**RICHARD ORRICK, DMD, MSD**