WATER TOWER DENTAL ltd

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MEDICAL HISTORY

Welcome to our office. Please complete this medical history form so we may be aware of any past or present health conditions. Further information may be included in Additional Comments section at the end of this form. Thank you.

Patient's name ____
LAST FIRST MIDDLE

Primary Care Physician ____________________ Date of Last Visit ____________ Physician's Phone ____________

Physician's Address ____
STREET CITY ZIP

Have you had allergies or reactions to any of the following?

Local anesthetics (novocaine, lidocaine, xylocaine) .... ☐ Yes ☐ No
Latex (gloves, balloons) .... ☐ Yes ☐ No
Metals (jewelry, clothing snaps) .... ☐ Yes ☐ No
Penicillin .... ☐ Yes ☐ No
Other antibiotics (if so, please list here ______________________) ☐ Yes ☐ No
Anti-inflammatory medications such as ibuprofen (Advil, Motrin), naproxen (Aleve), or aspirin .... ☐ Yes ☐ No
Other medications or substances ______________________

Please circle YES or NO or fill in where appropriate:

Have you ever taken any medications to strengthen your bones? .... ☐ Yes ☐ No
If Yes, please describe ______________________
Do you take antibiotic pre-medication before any dental procedures? .... ☐ Yes ☐ No
If Yes, please list ______________________
Do you now or have you ever smoked or chewed tobacco? .... ☐ Yes ☐ No
Have you noticed any changes in your face or jaws? .... ☐ Yes ☐ No
If Yes, please describe ______________________
Have you had any serious illness, operation or hospitalization within the past 5 years? .... ☐ Yes ☐ No
If Yes, please list ______________________
Have you ever or are you currently being treated for cancer, osteopenia, and/or osteoporosis? .... ☐ Yes ☐ No
If Yes, please explain ______________________
If so, were you given intravenous drugs, oral medications, or both? .... ☐ Yes ☐ No
Please list ______________________
Have you ever been involved in a serious accident? .... ☐ Yes ☐ No
If Yes, please explain ______________________
Do you have a history of a major illness? .... ☐ Yes ☐ No
If Yes, please explain ______________________
Any other physical problems? .... ☐ Yes ☐ No
If Yes, please describe ______________________
Do you currently have any shunts or ports? .... ☐ Yes ☐ No
Do you have breathing difficulties when reclined? .... ☐ Yes ☐ No
Are you thirsty or is your mouth dry much of the time? .... ☐ Yes ☐ No

List any prescription/non-prescription medications and nutritional supplements (incl. fluoride) you take:

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Please check any of the medical conditions, diseases or problems below that you have had or currently have.

- ☐ Abnormal bleeding/Hemophilia
- ☐ Arthritis
- ☐ Asthma, sinus trouble or hay fever
- ☐ Bone/Joints
- ☐ Cold sores/fever blisters/herpes
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Frequent headaches or migraines
- ☐ Heart (surgery, disease, attack)
- ☐ Hemophilia
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Rheumatic fever
- ☐ Stroke, angina or arteriosclerosis
- ☐ Tumors or Cancer
- ☐ Venereal disease
- ☐ Allergies or hives
- ☐ Artificial heart valve
- ☐ Autoimmune Disorder (please list) __________________________
- ☐ Bruise easily
- ☐ Congenital heart disease
- ☐ Diet (special/restricted)
- ☐ Epilepsy or seizures
- ☐ Gastrointestinal Disorders
- ☐ Heart defects, heart murmur
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Kidney trouble
- ☐ Nervous Disorders
- ☐ Sickle cell disease
- ☐ Swollen ankles
- ☐ Radiation therapy/chemotherapy
- ☐ Yellow jaundice
- ☐ Anemia
- ☐ Artificial joints (hip, knee, etc.)
- ☐ Blood disorder/transfusion
- ☐ Chest pain on exertion
  If so, do you take nitroglycerine? ☐ Y ☐ N
- ☐ Cortisone medicine
- ☐ Dizziness or fainting spells
- ☐ Frequent ear infections, colds, throat infections
- ☐ Glaucoma
- ☐ Heart pacemaker
- ☐ HIV or AIDS
- ☐ Liver disease
- ☐ Neurological disorder
- ☐ Stomach ulcer or hyperacidity
- ☐ Tuberculosis
- ☐ Respiratory problems

Please circle YES or NO or fill in where appropriate:

Do you have any medical condition, disease, or problem not listed on the previous pages? .... ☐ Yes ☐ No

If Yes, please explain ____

Do you have a current or past disease, condition, or problem you think we should know about but prefer to discuss privately rather than in writing? .... ☐ Yes ☐ No

Women:

Are you pregnant? .... ☐ Yes ☐ No

Are you nursing? .... ☐ Yes ☐ No

Are you taking birth control pills? .... ☐ Yes ☐ No

Additional Comments: ____

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I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any error or omissions that I may have made in the completion of this form.

Signature of patient ____ Date ______________________

Signature of guardian (if other than patient) ____ Date ______________________