BRIDGE CITY DENTAL

Medical Health History

Name: _____ Date of Birth: _____

Address: _____

Name of primary care physician

Last exam? _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No

If yes

Are you taking any medications, pills, or drugs? ○ Yes ○ No

If yes

Do you use tobacco? ○ Yes ○ No

Women: Are you…

○ Pregnant ○ Nursing ○ Taking oral Contraceptives?

Are you allergic to any of the following?

○ Aspirin	○ Penicillin	○ Codeine	○ Acrylic
○ Metal	○ Latex	○ Sulfa Drugs	○ Local Anesthetics

Other? ○ If yes

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

AIDS/HIV Postive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Diabetes	○ Yes ○ No	Hepatitis A, B, C	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
High Cholesterol	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Asthma	○ Yes ○ No
Fainting Spells/Dizziness	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Liver Disease	○ Yes ○ No	Bruise Easily	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No	Tumor or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Ulcers	○ Yes ○ No	Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No						

Have you ever had any serious illness not listed above? ○ Yes ○ No

If yes

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MEDICATION & OTHER PRODUCTS/SUBSTANCES

Are you taking any **blood thinners?** YES / NO

If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease? YES / NO

If yes, what medication are you taking? _____

Are you taking an **IV medication** to treat bone pain, hypercalcemia, or skeletal complications? YES / NO

If yes, what medication are you taking? _____ How many years? _____

MEDICAL & SURGICAL HISTORY

What is your normal blood pressure? (systolic, dyastolic) _____

Has a physician/previous dentist recommended that you take **antibiotics** before having dental work done? YES / NO

Have you had any type (either total or patial) of **joint replacement** surgery? YES / NO

Have you had any **heart valve replacement or heart surgery?** YES / NO

Have you had an **organ or bone marrow/stem cell transplant?** YES / NO

If you answered yes to any of the above, please explain: _____

_____

Is it hard to open your mouth?	YES / NO
Does it hurt to chew, bite, or swallow?	YES / NO
Do your gums bleed when you floss your teeth?	YES / NO
Have you ever have any sores or growths in your mouth?	YES / NO
Do you clench/grind your teeth?	YES / NO
Does your jaw click, pop, or hurt?	YES / NO
Do you have earaches or neck pains?	YES / NO
Does dental treatment make you nervous?	YES / NO
Have you ever experienced any of these sleep-related disorders? (Mouth breathing-Snoring-Trouble breathing during sleep)	YES / NO

Emergency Contact Name and Number: _____ Relationship: _____

To the best of my knowledge, the questions on this form have been accuretly answered. I understand that providing incorrect information can be dangerous for my (or patient's) health. It is my responsibility to inform the dental office of any changes to my medical health.

Signature: _____ Date: _____