west end dental
comprehensive & aesthetic dentistry

Patient Name_____

Date of Birth_____

MEDICAL HISTORY FORM

PLEASE CIRCLE THE APPROPRIATE ANSWER, IF YOU DO NOT KNOW, PLEASE WRITE "DON'T KNOW".
True and accurate answers are important for delivery of quality care. All info will be kept confidential.

1. Physician's name and phone number_____
2. Are you under a physician's care? YES NO Since when?_____
   Why? _____
3. When was your last complete physical exam?_____
4. Are you taking any medications? YES NO Please list
   _____
   _____
   _____
5. Do you take any health related substances? (Vitamins, supplements, etc) YES NO Please list_____
   _____
6. Are you allergic to any medications? YES NO If yes, please list _____
   _____
7. Do you have any other allergies? YES NO
8. Do you have any problems with Penicillin, antibiotics, anesthetics or other medications?..... YES NO
9. Are you sensitive to any metals or latex? YES NO
10. Are you pregnant or suspect that you may be?……..... YES NO
11. Do you use birth control? YES NO
12. Have you ever been treated for or been told you might have heart disease? …….. .YES NO
13. Do you have a pacemaker, artificial heart valve, or been diagnosed with mitral valve prolapse? YES NO
14. Have you ever had rheumatic fever? ……..…. YES NO
15. Are you aware of any heart murmur? YES NO
16. Do you have high or low blood pressure? (please circle which one) ……..... YES NO
17. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? YES NO
18. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? ……..... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO
20. Do you have any artificial joints/prosthesis? …….....YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? YES NO
22. Have you ever bled excessively after being cut or injured? ……... YES NO
23. Do you have any stomach problems? YES NO
24. Do you have any kidney problems? ……..... YES NO
25. Do you have any liver problems? YES NO
26. Are you diabetic? ……... YES NO
27. Do you have fainting or dizzy spells? YES NO
28. Do you have asthma? ……. YES NO
29. Do you have epilepsy or seizure disorders? YES NO
30. Do you or have you had venereal or any sexually transmitted disease? ……. YES NO
31. Do you have any reason to believe your immune system may be suppressed? YES NO
32. Have you had or do you test positive for hepatitis? ……... YES NO
33. Do you or have you had T.B.? YES NO
34. Do you have, or have you been treated for TMJ? ……. .YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO

36. Do you drink alcohol?.....YES NO
How often? _____/week month (please circle)

37. Do you habitually use controlled substances? ……. YES NO
38. Have you had psychiatric treatment? YES NO
39. Have you taken any prescription drugs Fenfluramine combined with Phentermine (fen-phen), Dexfenfluramine (redux), or other weight loss products?..... YES NO

40. Have you ever had a serious illness or major surgery? YES NO
If so, explain_____
_____

41. Have you ever had: (Please check all that apply)

- Excessive daytime sleepiness
- loud snoring
- observed episodes of breathing cessation during sleep
- abrupt awakenings accompanied by shortness of breath
- awakening with a dry mouth or sore throat
- morning headaches
- difficulty concentrating during the day
- experiencing mood changes such as depression or irritability
- difficulty staying asleep (insomnia)
- weight gain
- NONE of the above

42. Do you have any disease, condition, surgery, or problem not listed? If so, explain _____
_____
43. Is there anything else we should know about your health that we have not covered on this form?..... YES NO
44. Would you like to speak to the Doctor privately about any problem?..... YES NO

I understand the information I provide on this form is essential to determine my dental needs. I understand that if changes occur in my health, I must report it to the office as soon as possible. I certify that all the information I have provided is true and accurate.

Patient's/Guardian's signature _____Date_____

Dentist's signature _____Date_____