BRADBURN
DENTISTRY

# Medical History

Thank you for becoming a member of our dental family! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we get to know you, the better we can care for you.

Patient Name _____

## CURRENT MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician Name _____ Date of last visit (approximate) _____

Physician Phone _____

How would you describe your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| | | |
|---|---|---|
| Have you been hospitalized in the past 5 years? | ☐ Yes ☐ No | If yes, please describe _____ |
| Any serious illnesses/surgeries? | ☐ Yes ☐ No | If yes, please describe _____ |
| Is pre-medication required before dental visits? | ☐ Yes ☐ No | If yes, please describe _____ |
| Are you taking any prescription or daily OTC medications? | ☐ Yes ☐ No | If yes, please refer to medication information on page 2. |

Do/did you smoke tobacco or use tobacco of any form? (If yes, please complete all questions below.) ☐ Yes ☐ No

What type of tobacco do/did you use? _____ For how long? _____

Have you quit smoking or using tobacco? ☐ Yes ☐ No If yes, when did you quit? _____

If no, would you like to? ☐ Yes ☐ No

## ALLERGIES

Are you allergic to any of the following? None ☐

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Dental anesthetics | ☐ Latex | ☐ Sulfa drugs |
| ☐ Barbiturates | ☐ Erythromycin | ☐ Metals | ☐ Tetracycline |
| ☐ Codeine | ☐ Jewelry | ☐ Penicillin/other antibiotics | |

☐ Other please list _____

## YOUR MEDICAL HISTORY

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

None ☐

- ☐ Abnormal bleeding
- ☐ Acid reflux
- ☐ ADHD
- ☐ Alcohol/drug dependency
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Artificial bones/joints
- ☐ Asthma
- ☐ Autism/Asperger's
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Bulimia
- ☐ Cancer/Malignancy
- ☐ Colitis
- ☐ Congenital heart defect
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Dizziness/fainting
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Fainting spells
- ☐ Frequent headaches
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hepatitis
- ☐ Herpes/Cold Sores
- ☐ High blood pressure
- ☐ HIV/Aids
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Psychiatric problems
- ☐ Radiation/chemotherapy
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease/traits
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid condition
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal disease

☐ Other, please list here: _____

## MEDICATION INFORMATION

Are you currently taking any of the following?

None ☐

- ☐ Antibiotics/Sulfa Drugs
- ☐ Antihistamines/Allergy
- ☐ Daily Aspirin
- ☐ Blood Pressure Medications
- ☐ Blood Thinners
- ☐ Cancer/Chemo Medications
- ☐ Cortisone/Steroids
- ☐ Heart Medications/Digitalis
- ☐ Insulin
- ☐ Nitroglycerin
- ☐ Oral Contraceptives
- ☐ Osteoporosis Medications
- ☐ Other Diabetic Medications
- ☐ Recreational Drugs
- ☐ Thyroid Medications
- ☐ Tranquilizers

☐ Other, please list here:

| Name | Dosage | Reason prescribed |
|---|---|---|
| | | |
| | | |

## FEMALE PATIENTS

Female Patients:

Are you Pregnant? ☐ Yes ☐ No If so, what week are you? _____

Currently Nursing? ☐ Yes ☐ No Taking Birth control? ☐ Yes ☐ No

Is there anything about your medical condition we have not asked that you would like us to know?

_____

_____