William H. Pugh, D.D.S.

MEDICAL HISTORY (Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? If yes, nature of care? ◯ Yes ◯ No If yes

Have you ever been hospitalized or ever had a major operation? ◯ Yes ◯ No If yes

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Do you smoke or chew tobacco? How much per day? For how long? ◯ Yes ◯ No If yes

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes

Do you have a history of heart trouble/Disease?

- ☐ Heart attack/Failure
- ☐ Heart Transplant
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Congenital Heart Disorder
- ☐ Angina
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Stent Replacement
- ☐ Previous Bacterial Endocarditis

Do you take a blood thinner? If taking coumadin(warfarin), what was your last INR level? ◯ Yes ◯ No If yes

Do you take Aspirin daily? ◯ Yes ◯ No If yes

Have you ever been instructed to premedicate for any of the following?

- ☐ Artificial heart valve
- ☐ Congenital heart disorder
- ☐ Artificial Joint (hip/knee/shoulder)
- ☐ Organ Transpalnt

Did you premedicate for today's visit? ◯ Yes ◯ No

Have you been diagnosed with diabetes?

- ☐ Type I
- ☐ Type II

Have you recently had your HbA1c level checked and what was the level? ◯ Yes ◯ No If yes

Do you take any prescribed medications as recommended by your physician? ◯ Yes ◯ No If yes

Do you take any over the counter medications? ◯ Yes ◯ No If yes

Do you take any herbal supplements? ◯ Yes ◯ No If yes

Are you on a special diet? ◯ Yes ◯ No If yes

Women: Are you...

- ☐ Pregnant?
- ☐ Nursing?
- ☐ Taking birth control?
- ☐ Trying to get pregnant?

Are you allergic to or ever had a reaction to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Sunscreen/Benzocaine (Paba)
- ☐ Sulfite
- ☐ Epinephrine

Other? If yes to any or other, what was your reaction you experienced? ◯ Yes ◯ No If yes

Have you ever been told you have high blood pressure by a phycisian? ◯ Yes ◯ No If yes

What is your normal blood pressure?

Today's Blood Pressure

Do you use controlled substances? ◯ Yes ◯ No If yes

Do you snore during your sleep? ◯ Yes ◯ No If yes

Do you wake feeling refreshed? ◯ Yes ◯ No If yes

Have you ever been diagnosed with sleep apnea? ◯ Yes ◯ No If yes

If yes, do you use a CPAP machine or a lab made dental device? ◯ Yes ◯ No If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
Easily Winded ◯ Yes ◯ No	Herpes/Cold sores ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No
Rheumatism/RA ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No
Excessive Bleeding ◯ Yes ◯ No	Shingles ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No
Sickle Cell Disease ◯ Yes ◯ No	Asthma/COPD ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No
Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No
Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Seasonal Allergies ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No
Atrial Fibrilation ◯ Yes ◯ No	Anxiety/Depression ◯ Yes ◯ No	Prostate Problems/Cancer ◯ Yes ◯ No	Acid Reflux/Ulcers ◯ Yes ◯ No
Dry Mouth ◯ Yes ◯ No	Bleeding Gums ◯ Yes ◯ No	Sleep Apnea ◯ Yes ◯ No	

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

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

Signature of Patient, Parent or Guardian:

X Date:_____