Agawam Dental Associates

CONFIDENTIAL MEDICAL HISTORY

PATIENTS NAME_____ **DOB**_____ **SS#**_____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health.

Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

MEDICAL HISTORY- All questions must be answered.
* Write the answer to each question in the space provided using a ball point pen.
* If the question is not understood, you are not certain of the answer, or have any questions, indicate so in the space, and discuss the matter with the doctor.

Name of Physician_____ Phone_____

Person to notify in case of emergency_____ Phone_____

1. How would you describe your general health?_____
2. When was your last physical exam?_____
3. Are you now under the care of a physician?_____
   If yes, for what reason or condition?_____
4. Have you ever had an operation or serious illness?_____
   If yes please describe._____
5. Have you ever had any kind of radiation therapy?_____
   If yes please describe._____
6. Are you taking any medications non-prescription, vitamins or otherwise?_____
   If so, provide the name of the medication and for what reason or condition:
   _____
7. Do you take or have you ever taken Bisphosphonates(Fosamax)? _____
   a. Antibiotics or Sulfa drugs? _____
   b. Anticoagulants (blood thinners)? _____
   c. Blood Pressure Medication? _____
   d. Cortisone (steroids)? _____
   e. Tranquilizers? _____
   f. Antihistamines? _____
   g. Aspirin? _____
   h. Insulin, tolbutamide(Orinase) or similar drug?_____
   i. Nitroglycerin, Digitalis or drugs for heart trouble? _____
   j. Oral contraceptive or other hormonal therapy? _____
   l. Cold Medication? _____
   m. AZT? _____
   n. Other? _____
8. Are you allergic to, or have you reacted adversely to any medications? _____
   If yes, please name the medication and describe the reaction (for example: local Injected anesthetics, Penicillin or other antibiotics, sulfa drugs, barbiturates, sedatives, or sleeping pills, Aspirin, Iodine, Codeine or other narcotics):
   _____
   a. Allergic to Latex? _____

9. Do you have a persistent cough greater than 3 weeks duration? _____
   a. A cough that produces blood? _____

10. Do you have or have you ever had, or been treated for:
   a. Heart Murmur? _____
   b. Heart disease or other heart problems (heart attack, angina, heart surgery, pacemaker, or irregular heartbeat)? _____
   c. Rheumatic fever, rheumatic heart disease? _____
   d. Congenital heart defects? _____
   e. Stroke? _____
   f. Abnormal blood pressure? _____
   g. Abnormal reactions or excessive bleeding associated with previous extractions, surgery, or trauma? _____
   h. Anemia or other blood disorder? _____
   i. Have you ever had a blood transfusion? _____
   j. Allergies such as skin rashes, hay fever? _____
   k. Asthma or persistent cough? _____
   l. Sinus trouble? _____
   m. Venereal disease? _____
   n. Psychiatric or emotional problems? _____
   o. Tuberculosis or lung disease? _____
   p. Diabetes? _____
   q. Epilepsy? _____
   r. Dizziness, lightheadedness or fainting spells? _____
   s. Seizures or other neurological disorders? _____
   t. Cancer? _____
   u. Kidney problems or renal dialysis? _____
   v. Ulcers or other stomach or intestinal disease? _____
   w. Rheumatism, Arthritis or joint replacement? _____
   x. Hepatitis, jaundice or liver disease? _____
   y. Have you been exposed to the AIDS virus? _____
   z. Glaucoma? _____

11. For women, do you suspect you are pregnant? _____ If so, for how long? _____
12. Do you smoke? _____ If so, how often? _____
13. Do you drink alcoholic beverages? _____ If so, how much? _____
14. Do you use recreational drugs? _____ (In combination with certain medications used in dental procedures, Recreational drugs can be life threatening.)
15. Do you have any other disease, condition, or problem not covered above? _____
    If so, please describe. _____

I acknowledge that the responses I have given to the above questions concerning my present health status are accurate, to the best of my knowledge. I will alert the dental personnel of any changes in my health status at subsequent visits to Agawam Dental Associates.

Signature_____ **Date**_____

MEDICAL UPDATE: