MEDICAL HISTORY FORM

Name:______________________________ Date:______________________________

Date of Birth: ________________________ Sex: M / F Height:________Weight: ____________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Who referred you to GPC Oral Surgery and Dental Implant Center?__________________________

2. List your dental or oral complaints: ____

____

3 Are you in good health? .... Yes No

4. Has there been any change in your health in the past year? .... Yes No
If so, please explain:____

____

5. My last physical exam was on ___________/_____/_____

6. Are you now under the care of a physician? .... Yes No
If so, for what condition? ____

____

7. The name and address of my physician is: ____

____

8. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
If so, please list?____

____

9. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? .... Yes No
If so, when was the surgery?____

10. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)? .... Yes No

If yes, when were you taking these medications?___________________________

11. Are you taking any Prescription medicine(s): .... Yes No

If so, please list: ______________________________

____

12. Are you taking any diet pills, non-prescription, vitamins, homeopathic or natural remedies? Yes No

If so, please list: ______________________________

____

13. Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves, artificial valves or heart murmur .... Yes No
b. Rheumatic Heart Disease .... Yes No
c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition .... Yes No
   If so, please list ______________________________
   1. Chest pain upon exertion? .... Yes No
   2. Shortness of breath after mild exercise? .... Yes No
   3. Do your ankles swell? .... Yes No
d. Seasonal Allergies .... Yes No
e. Sinus trouble .... Yes No
f. Asthma or hay fever .... Yes No
g. Fainting spells or seizures .... Yes No
h. Diabetes .... Yes No
i. Hepatitis .... Yes No
j. Frequent or recurring mouth sores .... Yes No
k. Thyroid problems .... Yes No
l. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
m. Arthritis or painful, swollen joints including jaw joint (TMJ) .... Yes No
n. Osteoporosis .... Yes No
o. Stomach ulcer or hyperacidity .... Yes No
p. Kidney trouble .... Yes No
q. Tuberculosis .... Yes No
r. Persistent cough or cough that produces blood .... Yes No
s. Persistent swollen neck glands .... Yes No
t. Low blood pressure .... Yes No
u. Epilepsy or neurological disorder .... Yes No
v. Cancer .... Yes No
w. Liver disease or jaundice .... Yes No
x. Any disease, drug or transplant operation that has depressed your immune system .... Yes No
   If so, please list ______________________________

14. Have you had abnormal bleeding? .... Yes No
   If so, please explain ______________________________
   a. Have you ever required a blood transfusion? .... Yes No
      Please explain ______________________________

15. Do you have any blood disorder such as anemia? .... Yes No

16. Have you ever had treatment for a tumor or growth? .... Yes No
Please explain____

17. Have you had radiation therapy to the head, neck or jaws? .... Yes No

18. Do you have any allergies? Please list_________________________________ Yes No

____

19. Have you had any serious trouble associated with previous dental treatment? .... *Yes* No
If so, explain:____

____

20. Do you have any other condition or disease you think the doctor should know about? .... Yes No
If so, explain:____

21. Do you smoke or chew Tobacco? .... Yes No
How much? ______________________________

22. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? .... Yes No
Please explain:____

23. Are you wearing contact lenses? .... Yes No

24. Are you wearing removable dental appliances? .... Yes No

25. Do you wish to talk with the doctor privately about anything? .... Yes No

Women

26. Are you pregnant or trying to become pregnant .... Yes No
27. Do you have problems associated with your menstrual period? .... Yes No
28. Are you nursing? .... Yes No
29. Are you taking birth control pills? .... Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient/Guardian Signature_________________________________ Date:____/____/______