

# ACADEMY DENTAL GROUP

## MEDICAL HISTORY FORM

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF YOUR LAST PHYSICAL EXAMINATION \_\_\_\_\_ ARE YOU PRESENTLY IN GOOD HEALTH? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS? \_\_\_\_\_ IF YES, PLEASE LIST (OR ATTACH A SEPARATE LIST)

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_\_ IF YES, PLEASE LIST \_\_\_\_\_

ARE YOU ALLERGIC TO LATEX? \_\_\_\_\_ DO YOU REQUIRE PRE MEDICATION PRIOR TO DENTAL TREATMENT? \_\_\_\_\_

HAVE YOU HAD ANY UNUSUAL REACTION TO ANY OF THE FOLLOWING (**PLEASE CIRCLE**)

**FREEZING    ASPIRIN    PENICILLIN    CODEINE    SULPHA DRUGS    NSAIDS(ADVIL)**

DO YOU BRUISE OR BLEED EASILY? \_\_\_\_\_ IS YOUR JOB STRESSFUL? \_\_\_\_\_

HAVE YOU HAD ANY RECENT CHANGES IN WEIGHT, THIRST OR APPETITE? \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ IF YES, HOW MANY CIGARETTES PER DAY? \_\_\_\_\_ DO YOU USE COCAINE? \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (**PLEASE CHECK**)

HEART TROUBLE

KIDNEY PROBLEMS

HIGH OR LOW BLOOD PRESSURE

DIABETES

BLOOD OR CIRCULATORY DISORDERS

LUNG DISEASE OR TUBERCULOSIS

RHEUMATIC FEVER

THYROID DISORDER

HEPATITIS A, B OR C

ASTHMA

AIDS OR HIV

SINUS PROBLEMS

CANCER, RADIATION OR CHEMOTHERAPY

ARTHRITIS

HERPES

STOMACH PROBLEMS

DRUG OR ALCOHOL ADDICTION

NERVE OR MENTAL DISORDERS

STROKE

JOINT REPLACEMENT (HIP, KNEE ETC..)

LADIES: ARE YOU PREGNANT? \_\_\_\_\_ IF YES, WHEN IS YOUR DUE DATE? \_\_\_\_\_

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