MEDICAL HISTORY

Name _____ Date of Birth _____

Physician's Name _____ Physician's Phone # _____

Have you ever needed to take antibiotics prior to dental work? Yes _____ No _____ Why? _____

Do you take antibiotics now prior to dental work? What? _____

Do you have or have you ever had the following:

	Yes	No
CARDIOLOGY:		
Angina/Chest Pain?	❑	❑
Heart Lesions or Abnormalities?	❑	❑
Please explain? _____		
Do you have a Heart Murmur?	❑	❑
Do you need to pre-medicate for it?	❑	❑
High Blood Pressure?	❑	❑
Low Blood Pressure?	❑	❑
Defibrilator or Pacemaker? If yes, when? _____	❑	❑
Stroke?	❑	❑
Heart Surgery?	❑	❑
If yes, when _____ Type _____		
Do you take Coumadin, Warfarin, Plavix? INR?	❑	❑
Do you take a baby Aspirin daily?	❑	❑
Other Heart Conditions?	❑	❑
Please explain _____		
Name of Cardiologist _____		
Phone # _____		
BLOOD DISORDERS:		
Anemia?	❑	❑
Do you bruise easily?	❑	❑
Excessive bleeding?	❑	❑
Other types of Blood Disorders?	❑	❑
If yes, please describe? _____		
CANCER:		
Human Papilloma Virus (HPV)?	❑	❑
Head, Neck or Oral Cancer?	❑	❑
Other types of Cancer? Please list below	❑	❑
_____		
Was it removed by Surgery?	❑	❑
Have you had Chemotherapy?	❑	❑
When? _____		
Have you ever had Radiation Therapy?	❑	❑
When? _____		
LIVER DISEASE:		
Hepatitis? Type _____	❑	❑
Other Liver Disorders? Type _____	❑	❑
WOMEN ONLY:		
Are you Pregnant?	❑	❑
What Trimester are you in? _____		
Are you breast feeding?	❑	❑
Do you take Birth Control Pills?	❑	❑

	Yes	No
NEUROLOGY/PSYCHOLOGY:		
Alzheimer's?	❑	❑
Seizures?	❑	❑
Fainting?	❑	❑
Nervousness?	❑	❑
Depression?	❑	❑
Anxiety?	❑	❑
Other _____	❑	❑
RESPIRATORY:		
Allergies?	❑	❑
Asthma?	❑	❑
Emphysema or COPD?	❑	❑
Other _____	❑	❑
MISCELLANEOUS:		
AIDS or HIV?	❑	❑
Arthritis?	❑	❑
Type? _____		
Artificial Joints?	❑	❑
When? _____ Do you need pre-med?	❑	❑
Diabetes?	❑	❑
Alcohol Addiction?	❑	❑
Drug Addiction?	❑	❑
Tuberculosis?	❑	❑
Gastric Reflux?	❑	❑
Thyroid Disease?	❑	❑
Are you taking any medications for osteoporosis (biphosphanates)?	❑	❑
What? _____		
How long are/were you taking it? _____		
Do you have any other disease, problem or condition not listed above?	❑	❑
Please explain _____		
_____		
Allergy to Latex?	❑	❑

ALLERGIES TO MEDICATIONS:
(i.e. Rash, Itching, Swelling)

_____

_____

_____

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE AND REASON YOU TAKE THEM:

_____

_____

_____

AUTHORIZATION AND RELEASE

I understand that this information will be held in the strictest confidence and it is my responsibility to inform Cooper Creek Dental of any changes in my medical status. I acknowledge that this information is true and I understand not being forthcoming with information may impede, hinder, or contraindicate my dental treatment and I will not hold the dentist liable for my misrepresentation of information. I authorize the dental staff to perform any necessary dental servies that I may need during disgnosis and treatment, with my informed consent. Upon diagnosis, I authorize the dentist to give me all the treatment options so I can make an informed decision. I authorize the dentist to perform the needed treatment and administer or prescribe any necessary medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Form 0517