BROOKSIDE DENTISTRY

Medical History

Patient Name_____ Date of Birth _____ Sex: M F

Medical doctor/clinic _____ Pharmacy _____

Y N Are you taking any prescription or non-prescription medications, vitamins, herbals, or supplements? (if yes, please list on back of this form or attach separate sheets)
Y N Are you allergic to any medication, local anesthetic, or materials?
Y N Have you ever had heart trouble?
Y N Do you have high/low blood pressure?
Y N Have you ever had a joint replacement? Which joint(s)_____When_____
Y N Have you ever been advised to take antibiotics before dental treatment?
Y N Do you have a pacemaker?
Y N Do you have diabetes? □ Type 1 □ Type 2 Last HbA1c level _____ Date _____
Y N Have you had any major surgery?
Y N Have you ever had a serious accident involving head injuries?
Y N Do you have a history of fainting?
Y N Have you been hospitalized within the past year?
Y N Do you use tobacco products? Which_____
Y N Have you ever bled excessively after being cut or injured?
Y N Have you had radiation, chemotherapy, or other cancer treatment?
Y N Have you tested HIV positive? Do you have AIDS?
Y N Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

Do you have or have you ever had:

Y N Any heart condition
Y N Stroke
Y N Heart attack
Y N Artificial/prosthetic heart valve
Y N Congenital heart disease (heart defects at birth)
Y N Organ transplant
Y N Bacterial endocarditis
Y N High cholesterol
Y N Thyroid condition
Y N Hepatitis or liver disease
Y N Epilepsy or seizure
Y N Ulcer or GERD
Y N Breathing problems
Y N Asthma
Y N Sinus problems
Y N Tuberculosis
Y N Kidney problems
Y N Cancer or malignancy
Y N Sexually transmitted disease
Y N Osteoporosis
Y N Drug addiction

Women:

Y N Are you pregnant or trying to get pregnant?
Y N Are you taking oral contraceptives?
Y N Are you nursing?

Please explain “yes” answers(use the back of this form if more space is needed):

_____
_____

Patient (or guardian) signature _____ Date _____

Reviewed with patient by _____ Date _____ BP _____

Medication list

Please include all prescriptions, non-prescription medications, vitamins, herbal remedies and supplements.

Medication name	What is it for?	Dosage	Frequency

Further explanations from the front side of this form / Anything else you would like us to know about your health: