

Westwood Dental Partners Medical History

Patient Name:

Birth Date:

Date Created:

Physician, Pharmacy, Emergency Contact

Physician's Name: Yes No If yes

Physician's Phone Number Yes No If yes

Emergency Contact's Name/ Number: Yes No If yes

Preferred Pharmacy: Yes No If yes

Pharmacy Phone Number: Yes No If yes

Do you require premedication with antibiotics for your visits? If Yes, state reason, and what drug Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Have you been hospitalized or had a major operation in the LAST 2 YEARS? Yes No If yes

Do you use tobacco/drugs? Yes No If yes

ALLERGIES

I am allergic to the following:

None <input type="radio"/> Yes <input type="radio"/> No	Latex <input type="radio"/> Yes <input type="radio"/> No	Penicillin <input type="radio"/> Yes <input type="radio"/> No	Ibuprofen <input type="radio"/> Yes <input type="radio"/> No
Codeine <input type="radio"/> Yes <input type="radio"/> No	Local Anesthetic <input type="radio"/> Yes <input type="radio"/> No	Gluten <input type="radio"/> Yes <input type="radio"/> No	Nuts <input type="radio"/> Yes <input type="radio"/> No

Other Allergies Not Listed Above:

Medications I am currently taking:

I HAVE, OR HAVE HAD THE FOLLOWING CONDITIONS:

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Dementia <input type="radio"/> Yes <input type="radio"/> No
Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No
Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/ Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No
Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No
Leukemia <input type="radio"/> Yes <input type="radio"/> No	GERD <input type="radio"/> Yes <input type="radio"/> No	Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No
Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No	Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No
Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No	Chest Pains <input type="radio"/> Yes <input type="radio"/> No
Heart Attack/ Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No
Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Defect <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No
Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No	Convulsions <input type="radio"/> Yes <input type="radio"/> No	AFIB <input type="radio"/> Yes <input type="radio"/> No

ANY OTHER HEALTH ISSUES WE HAVE MISSED: If yes

IF NEEDED, PLEASE EXPLAIN ANY OF THE ABOVE:

Women: Are you...

Pregnant/Trying? Nursing? Taking Oral Contraceptives?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my(or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date: _____