iDENTAL GROUP, PLLC

Name: ____ Date of Birth: __________________

PATIENT MEDICAL HISTORY

¿Do you have or have you ever had? If yes, please explain

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? YES NO________________________	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? YES NO____
Artificial joint placed anywhere in the body (heart valve, pacemaker, hip, knee)? YES NO____	Liver disease (jaundice, hepatitis A, B or C)? YES NO____
Kidney disease or kidney failure? If yes, did it require dialysis? YES NO_________________________________	Chemotherapy or transplant operation? Cancer? If yes please specify type and date of last treatment? YES NO ____
Clicking, popping or pain within the jaw joints and/or difficulty opening the mouth? Clench or grind teeth? YES NO ____	Seizures, convulsions, epilepsy, fainting or dizziness? YES NO ____
Significant weight loss or gain? YES NO ____	Have you had surgery within the past 3 years, been hospitalized or ever had any major operation? YES NO ____
Are you required to take antibiotics prior to dental treatment? YES NO _____________________	Are you taking medications, pills or drugs? YES NO ____
Are you under the care of a physician? YES NO____	Have you had treatment with a Periodontist? YES NO____
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? YES NO ____	Do you take or have you taken any diet pills or exercise supplements? YES NO ____
Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, severe coughing)? YES NO___________________________	¿Do you have any other disease, condition or problem not listed above? YES NO____

Alzheimer's Disease	Y N	Anaphylaxis	Y N	Arthritis	Y N	Thyroid Disease	Y N
Cold Sores/Fever Blisters	Y N	Genital Herpes	Y N	Diabetes	Y N	Drug/Alcohol Issue	Y N
Cortisone Medicine	Y N	Glaucoma	Y N	High Cholesterol	Y N	Herpes	Y N
Stomach ulcer/colitis	Y N	Hives or Rash	Y N	HIV/AIDS	Y N	HPV	Y N
Parathyroid Disease	Y N	Leukemia	Y N	Shingles	Y N	Mitral Valve Prolapse	Y N
Osteoporosis/Osteopenia	Y N	Hypoglycemia	Y N	Rheumatic Fever	Y N	Rheumatism	Y N
Mental Health Issues	Y N	Tumors or growths	Y N	Scarlet Fever	Y N	Sickle Cell Disease	Y N
Sinus or Nasal Problems	Y N	Spina Bifida	Y N	Venereal Disease	Y N	Neurological Disorder	Y N

Women only:

Is there a possibility you are pregnant? Y N	Are you nursing? Y N	Are you taking birth control pills or hormonal replacement? Y N

ALLERGIES Are you allergic to or have you had an adverse reaction to:

Codeine or other painkillers	Y N	Acrylic	Y N	Food Products	Y N
Aspirin, Motrin, Aleve, Ibuprofen	Y N	Metals	Y N	Sedatives, barbiturates	Y N
Local Anesthesia or Epinephrine	Y N	Latex	Y N	Sulfa Drugs	Y N
Penicillin or other antibiotic ____________		Other:			

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 or Guardian Signature of Doctor Date