DENVER
RESTORATIVE DENTISTRY

Patient Medical History

Patient Name: _____ Date: _____

What is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you take antibiotic pre-medication for your dental visits?

☐ Yes ☐ No

If yes to the above question, (A) for what condition, and (B) what type of antibiotic? _____

_____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Allergies
☐ Allergy- Acrylic
☐ Allergy- Aspirin
☐ Allergy- Codeine
☐ Allergy- Erythro
☐ Allergy- Hayfever
☐ Allergy- Latex
☐ Allergy- Local Anesthetics
☐ Allergy- Other:_____
☐ Allergy- Penicillin
☐ Allergy- Sulfa
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemotherapy
☐ Chest Pain/ Angina
☐ Diabetes
☐ Dialysis
☐ Dizziness
☐ Drug Addiction
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Head injuries
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/ AIDS
☐ Jaundice
☐ Kidney Disease
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Mental Disorder: _____
☐ Nervous Disorder: _____
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Other: _____ _____

If any conditions or alerts selected in the previous section need further clarification, please describe below:

_____

_____

Primary Care Physician: _____ Date of last Exam: _____

Name and phone number of your preferred pharmacy: _____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin. _____
_____
_____
_____

Do you use any tobacco products (cigarette smoke or smokeless tobacco)?

☐ Smoker ☐ Ex-Smoker ☐ Non-Smoker ☐ Smokeless Tobacco (chew)

Do you use marijuana?

☐ Yes ☐ No

Do you use any controlled substances (i.e. OxyContin, Heroin, Cocaine, Methamphetamine)?

☐ Yes ☐ No

Have you previously or are you currently:

☐ Ever been hospitalized (illness or injury)
☐ Taking medication for weight control (i.e. fen-phen)
☐ Being treated for any other illness not listed
☐ Subject to frequent headaches
☐ Taking dietary supplements

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment? _____
_____

Have you had an orthopedic total joint replacement (hip, knee, elbow, shoulder, and ankle), if so, please list (A) which side (right/left), (B) which joint (hip, knee, elbow, shoulder, ankle), and (C) what year the surgery was performed: _____
_____
_____

Have you been diagnosed or treated for any cancer in the head and neck region?

☐ Yes ☐ No

If yes to the above question, (A) what type of cancer, (B) year of diagnosis and (C) what types of treatment were rendered (1. surgical resection, 2. chemotherapy, 3. radiation therapy)? _____
_____
_____

I acknowledge that I have reviewed ALL questions/ alerts on this questionnaire and responded accordingly. There are no other medical conditions or medication/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

_____ _____
Patient Name Date:

_____
Patient/ Guardian Signature