MEDICAL HISTORY

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Thank you for taking the time to complete this form! We know you fill out many papers. – Dr. B.

LAST NAME: _____ **FIRST NAME:** _____ **DATE OF BIRTH:** _____/_____/_____

Please indicate any that apply to you, and provide details when available:

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Chest pain/angina, when? _____
- ☐ Heart attack, when? _____
- ☐ Stroke, when? _____
- ☐ Heart valve replacement
  - ☐ Advised to premedicate with antibiotic?
- ☐ Implanted pacemaker and/or defib.
- ☐ Take blood thinner(s) _____
- ☐ Excessive bleeding/bruising

Staff: Today's BP: _____/_____

RESPIRATORY

- ☐ Smoke cigarettes / vape
  - ☐ Never
  - ☐ Quit: _____
  - ☐ Current: _____
- ☐ COPD
- ☐ Asthma
  - Carry rescue inhaler? Y / N
  - Last severe attack: _____
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Sinus trouble
- ☐ Trouble breathing through nose

SKELTOMUSCULAR

- ☐ Arthritis: Osteoarthritis / Rheumatoid
- ☐ Artificial joint(s), which? _____
  - ☐ Advised to premedicate with antibiotic?
- ☐ Osteoporosis
  - ☐ Current or history of treatment? _____
    _____

NERVOUS SYSTEM

- ☐ Seizures, triggered by: _____
- ☐ Vertigo
- ☐ Fibromyalgia
- ☐ Anxiety/depression
- ☐ Very high stress
- ☐ Aware of clenching/grinding teeth
- ☐ Frequent headaches
- ☐ High dental anxiety
  - ☐ Tried nitrous oxide / laughing gas?
  - ☐ Tried other sedation? _____
- ☐ Chemical dependency _____

REPRODUCTIVE

- ☐ Pregnant, due date _____
- ☐ Trying to become pregnant
- ☐ Nursing

ENDOCRINE / GENITO-URINARY

- ☐ Diabetes
  - Recent HbA1c _____
  - Is your physician satisfied with your control? Y / N
- ☐ Hyper-thyroid (high)
- ☐ Hypo-thyroid (low)
- ☐ Kidney disease

GASTROINTESTINAL

- ☐ Liver disease / Hepatitis
  - ☐ Avoid Tylenol/acetaminophen?
- ☐ GERD/acid reflux
- ☐ Ulcer
- ☐ Other GI condition: _____
- ☐ Avoid NSAIDs (Advil/ibuprofen, etc.)?

IMMUNE SYSTEM

- ☐ HIV/AIDS. Viral load _____
- ☐ Other Immunocompromise: _____

TUMORS / GROWTHS (part of body, approx. date)

- ☐ Cancer _____
  - ☐ Chemotherapy _____
  - ☐ Radiation _____
- ☐ Cancer status (active, remission, etc.): ____
  _____

ALLERGIES (circle any that apply): ☐ NO KNOWN DRUG ALLERGIES

Latex Penicillin Tetracycline Sulfa Codeine Aspirin NSAIDs Acrylic Metal(s): _____ Other: _____

MEDICATIONS (check one): ☐ NONE or ☐ LISTED BELOW or ☐ SEPARATE LIST PROVIDED TODAY

_____

OTHER SIGNIFICANT MEDICAL CONDITIONS (past or present) not listed above that you feel are important to communicate to Dr. Broderick?

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in medical status.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____/_____/_____ Doctor signature: _____

Rx:

OFFICE USE (update at each consultation and/or procedure visit)

DATE: _____/_____/_____ ☐ NO CHANGE (or) ☐ Change(s): _____ **Patient/Guardian signature:** _____

BP: _____/_____ Rx: Doctor signature: _____

DATE: _____/_____/_____ ☐ NO CHANGE (or) ☐ Change(s): _____ **Patient/Guardian signature:** _____

BP: _____/_____ Rx: : Doctor signature: _____

DATE: _____/_____/_____ ☐ NO CHANGE (or) ☐ Change(s): _____ **Patient/Guardian signature:** _____

BP: _____/_____ Rx: : Doctor signature: _____

DATE: _____/_____/_____ ☐ NO CHANGE (or) ☐ Change(s): _____ **Patient/Guardian signature:** _____

BP: _____/_____ Rx: : Doctor signature: _____