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ST. FRANCISVILLE
FAMILY DENTISTRY

225-635-6554

MEDICAL HISTORY FORM

Name:_____ Preferred Name:_____

Date of Birth: _____ Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on (Approx) ___/____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
6. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   If so, please list: _____

Pre-Medication Necessary

7. Have you had an artificial joint replacement or currently have metal pins, posts, or rods? .. Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa) ? ..... Yes No
9. Do you have or have you had damaged heart valves, artificial valves or heart murmur ..... Yes No
10. Do you have or have you had Bacterial Endocarditis (Infection of the heart) ..... Yes No
11. Do you have or have you had any congenital (present at birth) heart conditions ..... Yes No
12. Do you have or have you had a heart transplant ..... Yes No

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13. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other: List_____
14. Do you have or have you had any of the following diseases or problems?
    a. Any disease, drug or transplant operation that has depressed your immune system…. Yes No
    b. Rheumatic Heart Disease ..... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No

2. Shortness of breath after mild exercise? ..... Yes No
3. Do your ankles swell? ..... Yes No

d. Allergies ..... Yes No
e. Sinus trouble ..... Yes No
f. Asthma or hay fever ..... Yes No
g. Fainting spells or seizures ..... Yes No
h. Diabetes ..... Yes No
i. Hepatitis, jaundice or liver disease ..... Yes No
j. Frequent or recurring mouth sores ..... Yes No
k. Thyroid problems ..... Yes No
l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
n. Osteoporosis ..... Yes No
o. Stomach ulcer or hyperacidity ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough that produces blood ..... Yes No
s. Persistent swollen neck glands ..... Yes No
t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer ..... Yes No

15. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
16. Do you have any blood disorder such as anemia? ..... Yes No
17. Have you ever had treatment for a tumor or growth? ..... Yes No
18. Have you had radiation therapy or chemotherapy? ..... Yes No
19. Do you have AIDS or HIV ..... Yes No
20. Have you had or do you have Hepititis A, B, C, or D ..... Yes No
21. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
    _____
22. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
23. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____
24. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No

Women Only

25. Are you pregnant or trying to become pregnant ..... Yes No
26. Do you have problems associated with your menstrual period? ..... Yes No
27. Are you nursing? ..... Yes No
28. Are you taking birth control pills (**antibiotics may reduce effectiveness**)? ..... Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ Patient/ Legal Guardian Signature: _____