Muscaro & Martini DENTISTRY

Medical History

Muscaro & Martini Dentistry
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Patient Name _____ Nickname _____ Age _____

Name of Physician and their specialty _____ Phone Number _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

Please Answer:

1. Hospitalization for illness or injury _____ ◯ ◯
2. An allergic reaction to
   - ◯ aspirin, ibuprofin, acetaminophen, codeine
   - ◯ penicilin
   - ◯ erythromycin
   - ◯ tetracycline
   - ◯ sulpha
   - ◯ local anesthetic
   - ◯ flouride
   - ◯ metals (nickel, gold, silver, _____)
   - ◯ latex
   - ◯ other _____
3. Heart problems, or cardiac stent within the last 6 months ◯ ◯
4. History of infective endocarditis _____ ◯ ◯
5. Artificial heart valve, repaired heart defect (PFO) _____ ◯ ◯
6. Pacemaker or implantable defibulator _____ ◯ ◯
7. Artificial prosthesis (heart valve or joints) _____ ◯ ◯
8. Rheumatic or scarlet fever _____ ◯ ◯
9. High or low blood pressure _____ ◯ ◯
10. A stroke (taking blood thinners) _____ ◯ ◯
11. Anemia or other blood disorder _____ ◯ ◯
12. Prolonged bleeding due to a slight cut (INR >3.5) _____ ◯ ◯
13. Emphysema or sarcoidosis _____ ◯ ◯
14. Tuberculosis _____ ◯ ◯
15. Asthma _____ ◯ ◯
16. Breathing or sleeping problems (i.e. snoring, sinus) _____ ◯ ◯
17. Kidney disease _____ ◯ ◯
18. Liver disease _____ ◯ ◯
19. Jaundice _____ ◯ ◯
20. Thyroid, parathyroid disease, or calcium deficiency _____ ◯ ◯
21. Hormone deficiency _____ ◯ ◯
22. High cholesterol or taking statin drugs _____ ◯ ◯
23. Diabetes (HbA1c= _____) _____ ◯ ◯
24. Stomach or duodenal ulcer _____ ◯ ◯
25. Digestive disorders (i.e. gastric reflux) _____ ◯ ◯
26. Osteoporosis/ osteopenia (taking bisphosphonates) ◯ ◯
27. Arthritis _____ ◯ ◯
28. Glaucoma _____ ◯ ◯
29. Contact Lenses _____ ◯ ◯
30. Head or neck injuries _____ ◯ ◯
31. Epilepsy, convulsions (seizures) _____ ◯ ◯
32. Neurologic problems (attention deficit disorder) _____ ◯ ◯
33. Viral infections and cold sores _____ ◯ ◯
34. Any lumps or swelling in the mouth _____ ◯ ◯
35. Hives, skin rash, hay fever _____ ◯ ◯
36. Venereal disease _____ ◯ ◯
37. Hepatitis (type ___) _____ ◯ ◯
38. HIV / AIDS _____ ◯ ◯
39. Tumor, abnormal growth _____ ◯ ◯
40. Radiation therapy _____ ◯ ◯
41. Chemotherapy _____ ◯ ◯
42. Emotional problems _____ ◯ ◯
43. Psychiatric treatment _____ ◯ ◯
44. Antidepressant medication _____ ◯ ◯
45. Alcohol / drug dependency _____ ◯ ◯

ARE YOU:

46. Presently being treated for any other illness _____ ◯ ◯
47. Aware of a change in your general health _____ ◯ ◯
48. Taking medication for weight management (i.e. fen-phen) ◯ ◯
49. Taking dietary supplements _____ ◯ ◯
50. Often exhausted or fatigued _____ ◯ ◯
51. Subject to frequent headaches _____ ◯ ◯
52. A tobacco user _____ ◯ ◯
53. Considered a touchy or oversensitive person _____ ◯ ◯
54. Often unhappy or depressed _____ ◯ ◯
55. FEMALE - taking birth control pills _____ ◯ ◯
56. FEMALE - pregnant _____ ◯ ◯
57. MALE - prostate disorders _____ ◯ ◯

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

Drug	Purpose	Drug	Purpose

Ask for additional sheet if you are taking more than 4 medications.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____