Medical History

Muscaro & Martini Dentistry
3502 W. Bay To Bay Blvd., Tampa, FL 33629
813.839.6999 • Fax 813.831.1670

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

Please Answer:

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
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 / cardiac stent within the last 6 months	○	○
4. History of infective endocarditis _____	○	○
5. Artificial heart valve / repaired heart defect (PFO) _____	○	○
6. Pacemaker / implantable defibulator _____	○	○
7. Artificial prosthesis (heart valve or joints) _____	○	○
8. Rheumatic / scarlet fever / heart murmur _____	○	○
9. High or low blood pressure _____	○	○
10. A stroke (taking blood thinners) _____	○	○
11. Anemia / other blood disorder _____	○	○
12. Prolonged bleeding due to a slight cut (INR >3.5) _____	○	○
13. Emphysema / sarcoidosis / pneumonia _____	○	○
14. Tuberculosis / measles / chicken pox _____	○	○
15. Breathing problems / asthma / sinusitis _____	○	○
16. Sleeping problems (i.e. snoring, insomnia) _____	○	○
17. Kidney disease _____	○	○
18. Liver disease / jaundice _____	○	○
19. Vertigo _____	○	○
20. Thyroid / parathyroid disease / calcium deficiency _____	○	○
21. Hormone deficiency / imbalance _____	○	○
22. High cholesterol / taking statin drugs _____	○	○
23. Diabetes (HbA1c= _____) _____	○	○
24. Stomach or duodenal ulcer _____	○	○
25. Digestive or eating disorders _____	○	○
26. Osteoporosis / osteopenia (taking bisphosphonates)	○	○
27. Arthritis / gout _____	○	○
28. Autoimmune disease _____	○	○
29. Glaucoma _____	○	○
30. Contact lenses _____	○	○
31. Head or neck injuries _____	○	○
32. Epilepsy / convulsions (seizures) _____	○	○
33. Neurologic problems (attention deficit disorder) _____	○	○
34. Viral infections and cold sores _____	○	○
35. Any lumps or swelling in the mouth _____	○	○
36. Hives / skin rash / hay fever _____	○	○
37. Venereal disease _____	○	○
38. Hepatitis (type ___) _____	○	○
39. HIV / AIDS _____	○	○
40. Tumor / abnormal growth _____	○	○
41. Radiation therapy _____	○	○
42. Chemotherapy / immune suppressants _____	○	○
43. Emotional problems _____	○	○
44. Psychiatric treatment / antidepressant medication ____	○	○
45. Concentration problems / ADD / ADHD diagnosis ____	○	○
46. Alcohol / drug dependency _____	○	○
ARE YOU:		
47. Presently being treated for any other illness _____	○	○
48. Aware of a change in your general health _____	○	○
49. Taking medication for weight management (i.e. fen-phen)	○	○
50. Taking dietary supplements _____	○	○
51. Often exhausted / fatigued _____	○	○
52. Subject to frequent headaches / chronic pain _____	○	○
53. A tobacco user _____	○	○
54. Considered a touchy or oversensitive person _____	○	○
55. Often unhappy / depressed _____	○	○
56. FEMALE - taking birth control pills _____	○	○
57. FEMALE - pregnant _____	○	○
58. 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 _____