Masterpiece Family & Cosmetic Dentistry   Medical Health History

Patient Name:________________________ DOB:__________ Date:__________

Date of last health care exam by a medical doctor:______ What was exam for?__________________

Have you been hospitalized in the last 5 years? (Please Circle) No Yes For what?__________________

Are you currently receiving care? No Yes If yes, nature of care:__________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1.________________________ 3.________________________

2.________________________ 4.________________________

For the following questions circle yes or no if you have ever been diagnosed, or treated in the past, or are now being treated for, or are aware of any of the following. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? Year placed?	No	Yes
Asthma	No	Yes	Kidney Disease or Problems	No	Yes
Inhaler, Advair, Breathing Treatments?	No	Yes	Liver Disease (including Jaundice) or Problems	No	Yes
Cancer or Tumor? Year?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes (HbAlc #?)	No	Yes	Numbness in feet or toes?	No	Yes
Emphysema or other Respiratory/Lung Illness	No	Yes	Previous Biopsies? Year?	No	Yes
Epilepsy	No	Yes	Radiation or chemotherapy Treatment? Year?	No	Yes
Glaucoma/ Eye Problems	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) of Heart Transplant	No	Yes	H.I.V. infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Sexually Transmitted Condition	No	Yes
Heart Disease, Heart Attack, Heart Surgery?	No	Yes	Heart murmur/Irregular heart beat	No	Yes
Heart Stent? Year Placed?	No	Yes	Rheumatic Fever	No	Yes
Coumadin/ Blood thinners?	No	Yes	Recurrent Illness	No	Yes
Depression/Panic Attacks/Mood Swings	No	Yes	Migraine/Severe Headaches	No	Yes
Sleep Difficulties/Sleep Apnea	No	Yes	Stomach Ulcers/Problems/Reflux	No	Yes
High Blood Pressure	No	Yes	High Cholesterol	No	Yes
Mitral-Valve Prolapse	No	Yes	Previous Alcohol or Drug Abuse/Addiction?	No	Yes
Fainting or Dizzy Spells/Angina (4 Questions)	No	Yes	Psychological issues/Post Traumatic Stress etc.	No	Yes
Blood Transfusion? Year?	No	Yes	Abnormal Bleeding from a cut?	No	Yes

Are you taking any of these medications?

Pre-Medication before dental treatment?	No	Yes	Tagamet (cimetidine) or Prilosec (omeprazole)?	No	Yes
Antacids? (Pepsid Ac, etc.)	No	Yes	CadiZem (diltiaZem) or Calan, Isoptin (Verapamil)?	No	Yes
Barbiturates (any)	No	Yes	Diflucan (fluconazole) or Sporonox (itraconazole)?	No	Yes
St. Johns's Wort or Kava-Kava?	No	Yes	Biaxin (clarithromycin), Erythromycin?	No	Yes
Lunesta, Ambian?	No	Yes	Tetracycline, Doxycycline?	No	Yes
Dilantin or Tegretol?	No	Yes	Serzone (nefazodone)?	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruit extract?				No	Yes

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Medical Health History

Patient Name:______________________________________ Date:______________

Women: Are you pregnant? (Circle One) No Yes

Is there a possibility that you may be pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you using any birth control contraceptives? (pills, injections/shots, IUD (Mirena) No Yes

Abnormal Blood Pressure? (Please Circle)

Have you ever received a diagnosis of "high blood pressure"?

What is your normal blood pressure? S______/D_______ Today S_______/D_______

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Antibiotics – If so, Please list No Yes ____
   Please List Antibiotics you are allergic to
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or other sedatives No Yes
e. Latex or Metals No Yes
f. Sulfa Drugs, Iodine No Yes
g. Other (please specify)_____________________

Tobacco, Alcohol, Drugs, Caffeine

Do you use tobacco? If yes, circle type: smoke chew "dip" How much per day? How long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight/ Height	Meals per Day	Dietary Restrictions	Food Allergies
_______ lbs. _______ Hgt.	________	High Fiber No Yes High Fat No Yes High Protein No Yes High Carb No Yes	____________________ ____________________ ____________________ ____________________
Sugar in your diet (circle one): None Slight Moderate High			

Soft Drinks? No Yes If yes: How much?_____ How many/day?______ Which type?______________

Coffee or Tea (sweetened/unsweetened)? No Yes

If yes: How much?_____ How many/day?______ Which type?______________

Do you have any medical condition or problems not listed above that I should know about? No Yes

If so, explain: ____

Have you had any serious trouble associated with previous medical treatment? No Yes

If so explain: ____

Do you exercise regularly? How often?______________________________ No Yes

Are you wearing contact lenses? No Yes

Does jewelry (rings, wristwatch) turn your skin black after you have worn it? No Yes

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Medical Health History

Patient Name:____ Date:________________

Please list any medications you are currently taking dosages: (Write on back if you need more room)

1.____ 2.____

3.____ 4.____

5.____ 6.____

7.____ 8.____

9.____ 10.____

Please list any dietary or herbal supplements you are taking, and for what purpose: (Write on back if you need more room)

1.____ 2.____

3.____ 4.____

5.____ 6.____

7.____ 8.____

Please list any other "over the counter" medications that you take and dosages/ how often:
(ex. Zantac, Rolaids, cough syrups, diet pills, BC powders, Tylenol, Tylenol PM anti-histamines etc.)

1.____ 2.____

3.____ 4.____

5.____ 6.____

7.____ 8.____

Doctor's Use Only
Comments on patient interview concerning medical history:

____

____

Significant findings from questionnaire or oral interview:

____

____

Dental management considerations: ASA: I II III IV

____

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I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Dr. Goodman or staff members of Masterpiece Family & Cosmetic Dentistry of any changes in my health and/or any medications.

______________________ ______________________ ______________________
Patient (Print Name) Patient Signature Date

Dr. Derek Goodman______ ______________________ ______________________
Doctor Name Doctor Signature Date