Strobel Family Dentistry

Medical History

(PLEASE PRINT) Patient's Name _____ Date ___/___/_____

Date of Birth Name of physician and his/her specialty

_____

Most recent physical examination Purpose

_____

Do you or have you ever had: YES/NO

1. Hospitalization for illness or injury _____ ☐ ☐
2. An allergic reaction to:
   - ☐ aspirin, ibuprofen, acetaminophen
   - ☐ penicillin
   - ☐ tetracycline
   - ☐ codeine
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (gold, stainless steel, costume jewelry)
   - ☐ latex
   - ☐ other _____
3. Heart problems/chest pain _____ ☐ ☐
4. Artificial heart valve _____ ☐ ☐
5. Congenital heart defect _____ ☐ ☐
6. Bacterial endocarditis _____ ☐ ☐
7. High blood pressure _____ ☐ ☐
8. Low blood pressure _____ ☐ ☐
9. A stroke _____ ☐ ☐
10. Artificial prosthesis (i.e. heart valve or joints)___ ☐ ☐
11. Prolonged bleeding _____ ☐ ☐
12. Lung disease _____ ☐ ☐
13. Tuberculosis _____ ☐ ☐
14. Asthma _____ ☐ ☐
15. Breathing or sleep problems (i.e. snoring, sinus) ☐ ☐
16. Kidney disease _____ ☐ ☐
17. Liver disease _____ ☐ ☐
18. High cholesterol _____ ☐ ☐
19. Diabetes (type) _____ ☐ ☐
20. Stomach ulcer _____ ☐ ☐
21. Digestive disorders (i.e. gastric reflux) _____ ☐ ☐

YES/NO

22. PROSTHETIC JOINT REPLACEMENT _____ ☐ ☐
    (hip, knee, etc.)
23. Bulimia _____ ☐ ☐
24. Anorexia _____ ☐ ☐
25. Osteoporosis/osteopenia _____ ☐ ☐
    (i.e. taking bone-hardening drugs)
26. Arthritis _____ ☐ ☐
27. Epilepsy, convulsions (seizures) _____ ☐ ☐
28. Venereal disease _____ ☐ ☐
29. Hepatitis (type) _____ ☐ ☐
30. HIV/AIDS _____ ☐ ☐
31. Tumor, abnormal growth _____ ☐ ☐
32. Radiation therapy _____ ☐ ☐
33. Chemotherapy _____ ☐ ☐
34. Antidepressant medication _____ ☐ ☐
35. Alcohol/drug dependency _____ ☐ ☐
36. Blood transfusion _____ ☐ ☐

Are you:

37. Presently being treated for any other illness ☐ ☐
    _____
38. Subject to frequent headaches _____ ☐ ☐
39. A smoker or smoked previously _____ ☐ ☐
40. A user of chewing tobacco _____ ☐ ☐
41. Female — taking birth control pills _____ ☐ ☐
42. Female — pregnant _____ ☐ ☐

(SEE NEXT PAGE)

Medical History (p. 2)

(PLEASE PRINT) Patient's Name _____ Date ___/___/_____

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

_____

_____

_____

List all current medications or supplements. (Please ask for an additional sheet if you are taking more than six medications.)

Drug	Purpose
Drug	Purpose
Drug	Purpose
Drug	Purpose
Drug	Purpose
Drug	Purpose

Please advise us in the future of any changes in your medical history or any medications you may be taking.