BananaRiver DENTAL

MEDICAL HISTORY FORM

Patient Name: _____ PCP, Medical Doctor: _____

HEART

Have you had a heart attack before? Yes [ ] No [ ]

-If yes, when was that? _____

Have you had a stroke before? Yes [ ] No [ ]

-If yes, when was that? _____

Do you have high blood pressure? Yes [ ] No [ ]
Do you have an artificial heart valve? Yes [ ] No [ ]
Are you taking any blood thinners? Yes [ ] No [ ]
Do you bleed excessively? Yes [ ] No [ ]
Do you have congestive heart failure? Yes [ ] No [ ]
Do you have a pacemaker? Yes [ ] No [ ]

DIABETES

Are you diabetic? Yes [ ] No [ ]

-If yes, controlled w/ Insulin [ ] Meds [ ]

LIVER/KIDNEY

Do you have liver problems Yes [ ] No [ ]
Do you have kidney problems? Yes [ ] No [ ]

CANCER

Have you ever had cancer? Yes [ ] No [ ]

If yes, which type(s) _____

If yes, did you have Chemo [ ] Current Chemo? [ ]

Head and/or Neck Radiation? [ ] _____

BONE/JOINTS

Have you ever taken a Bisphosphonate drug? Yes [ ] No [ ]

(usually either a pill, IV or monthly shot for Osteoporosis or certain types of cancer)

Do you have an artificial/prosthetic joint? Yes [ ] No [ ]

(usually knee, hip or shoulder)

MEDICATIONS YOU CURRENTLY TAKE: None [ ]

(You can also use the back of this sheet if needed, or we can scan a list if you have one)

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: Penicillin/Amoxicillin [ ] Aspirin [ ]

Codeine [ ] Metal [ ] Sulfa Drugs [ ]

Ibuprofen [ ] Latex [ ] Novocaine [ ]

Epinephrine [ ] No known allergies [ ]

Other_____

MISCELLANEOUS Alzheimer's/Dementia [ ]

Seizures [ ] AIDS/HIV [ ] Hepatitis A [ ]

Hepatitis B/C [ ] Asthma [ ] Lung Disease/COPD [ ]

Emphysema [ ] Pregnant/Trying to get Pregnant [ ]

Nursing [ ]

Other _____

Comments or anything not listed above that would help us take care of you safely?_____

_____

Signature of Patient, Parent or Guardian_____ **Date** _____