PATIENT MEDICAL HISTORY

Patient Name: _____ Nickname:_____ Date of Birth:_____

Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain in this office.

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

GENERAL HISTORY

1. Are you in good health? ☐ ☐
2. Have there been any changes in your general health within the past year? ☐ ☐
3. Are you now under the care of a physician? ☐ ☐
4. Date of last physical examination: ☐ ☐
5. Have you ever been hospitalized for any surgical operations or serious illness? ☐ ☐
   Please Explain: _____
   _____
6. Describe any current medical treatment, impending surgery or other treatment (e.g. Botox collagen injections etc) that may possibly affect your dental treatment: ☐ ☐
   _____
7. Are you taking any medicine(s) including non-prescription medicine? If yes please list. (If you are taking more than 6 medications, please attach a separate sheet.) ☐ ☐

Drug	Purpose
1.	
2.	
3.	
4.	
5.	
6.	

8. Have you had any abnormal bleeding? (i.e. prolonged bleeding due to a slight cut) ☐ ☐
9. Do you bruise easily? ☐ ☐
10. Have you ever required a blood transfusion? ☐ ☐
11. Have you had an organ transplant? ☐ ☐
12. Have you had recent weight loss or gain? ☐ ☐
13. Are you a smoker, smoked previously, or use smokeless tobacco? ☐ ☐
14. Do you or have you used controlled substances (street drugs)? ☐ ☐
15. Have you had recent exposure to communicable infectious diseases (e.g. measles, chicken pox, TB, prion disease, or travel to an endemic area)? ☐ ☐
16. In the last 24 hours have you had new cough, shortness of breath, fever, rash, chills, diarrhea, or other flu like symptoms? ☐ ☐

WOMEN ONLY

1. Are you pregnant or think you may be pregnant? Due date: ☐ ☐
2. Are you nursing? ☐ ☐
3. Are you taking birth control pills? ☐ ☐

MEN ONLY

1. Prostate disorder? ☐ ☐

ALLERGIES

1. Are you allergic to or have you had reactions to (check only the boxes which apply):

☐ Aspirin, ibuprofen, acetaminophen, codeine
☐ Penicillin or other antibiotics
☐ Latex
☐ Barbiturates, sedatives or sleeping pills
☐ Sulfa Drugs
☐ SLS
☐ Metal (e.g. nickel, gold, silver etc.)
☐ Anesthetic
☐ Others (please list): _____

SPECIFIC DISEASES/DISORDERS/INFECTIONS

1. Do you or have you ever had the following (check only the boxes which apply):

☐ Rheumatic fever/heart disease
☐ Scarlet fever
☐ Jaundice or liver disease
☐ Congenital heart malformation
☐ Cough that produces blood
☐ Cirrhosis of the liver
☐ Heart arrhythmia
☐ Tuberculosis (TB)
☐ Asthma or hay fever
☐ Heart Surgery
☐ Persistent cough
☐ Sinus trouble
☐ High/low blood pressure
☐ Hives or skin rash
☐ Fainting or dizzy spells
☐ Heart attack or angina
☐ Stomach ulcer
☐ Diabetes Type I/II HbA1C=
☐ Do you take Coumadin INR=
☐ Kidney trouble/dialysis
☐ Celiac disease
☐ Congestive heart failure
☐ Cancer
☐ Radiation treatment/chemotherapy
☐ Heart defect or heart murmur
☐ Anemia
☐ Calcium deficiency
☐ Mitral valve prolapse
☐ Sickle cell anemia
☐ Corticosteroid treatment
☐ Pacemaker
☐ Artificial joints
☐ Lung or breathing problems
☐ Stroke
☐ Glaucoma
☐ Inflammatory bowel disease
☐ High cholesterol
☐ Cold sores
☐ Thyroid/parathyroid disease
☐ Epilepsy or seizure
☐ Tonsillitis
☐ Chemical dependency
☐ Mental health care
☐ Anxiety
☐ Eating disorder
☐ Alzheimer's/Dementia
☐ HIV/AIDS
☐ Hepatitis A, B, C, D, E, F
☐ Sexually transmitted infections
☐ Arthritis or rheumatism. (If yes, are you taking bisphosphonates?)

2. Do you have any infections disease, condition or problem not listed above, or are you presently being treated for any other illness? _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been correctly answered. I understand that not providing correct information can be dangerous to my health. If there are any changes to my health or if my medications change, I will inform the doctor or health care provider without fail.

DATE: _____ **X** _____
Signature of patient or legal guardian

TREATMENT PHOTOGRAPHS

During the course of your treatment photographs may be taken for before and after records, shade selection etc. I consent to allowing doctors Swanlund & Graas to use these photos for educational purposes.

DATE: _____ **X** _____
Signature of patient or legal guardian