

Central Park Dental Group

MEDICAL

HISTORY

- | | | |
|--|-------------------------------------|--------------------------------------|
| 1. Are you in good health? | YES | NO |
| 2. Have you been hospitalized or had a serious illness in the last three years? | YES | NO |
| 3. Are you being treated by a physician now? | YES | NO |
| 4. Do you need to take antibiotics before dental visits? | YES | NO |
| 5. Are you allergic or sensitive to drugs or local anesthetics? | YES | NO |
| 6. Indicate which of the following you have had or have. Please circle YES or NO . | | |
| Diabetes ----- YES NO | Smoking ----- YES NO | Swollen ankles ----- YES NO |
| Heart Attack ----- YES NO | Alcohol use ----- YES NO | Shortness of breath ----- YES NO |
| Heart Failure ----- YES NO | Tobacco use ----- YES NO | Dizziness, nausea ----- YES NO |
| Heart Surgery ----- YES NO | Recreational drug use ----- YES NO | Fainting ----- YES NO |
| High/Low Blood Pressure ----- YES NO | Bleeding problems ----- YES NO | Headaches, migraines ----- YES NO |
| Stroke ----- YES NO | Sinus problems ----- YES NO | Anemia, blood disease ----- YES NO |
| Heart Murmur ----- YES NO | Vomiting ----- YES NO | Glaucoma, cataract ----- YES NO |
| Hepatitis ----- YES NO | Stomach problems, ulcers --- YES NO | Eye Disease ----- YES NO |
| Mitral Valve Prolapse ----- YES NO | Diarrhea ----- YES NO | Head Injuries ----- YES NO |
| Prosthetic Heart Valve ----- YES NO | Constipation ----- YES NO | Body Injuries ----- YES NO |
| Joint Replacement ----- YES NO | Rheumatic fever ----- YES NO | Jaundice ----- YES NO |
| Hip Replacement ----- YES NO | Rheumatism ----- YES NO | Liver Disease ----- YES NO |
| Pacemaker ----- YES NO | Arthritis ----- YES NO | Bladder Disease ----- YES NO |
| Seizure, epilepsy ----- YES NO | Asthma ----- YES NO | Kidney Disease ----- YES NO |
| Cancer, tumor ----- YES NO | Tuberculosis ----- YES NO | Thyroid Disease ----- YES NO |
| Radiation therapy ----- YES NO | Emphysema ----- YES NO | Venereal Disease ----- YES NO |
| Chemotherapy ----- YES NO | Lung disease ----- YES NO | Mental Illness ----- YES NO |
| AIDS ----- YES NO | Allergies to food ----- YES NO | Nervousness ----- YES NO |
| HIV Positive ----- YES NO | Allergies to latex ----- YES NO | Recent weight loss or gain -- YES NO |
| 7. Are you currently taking or have taken: | | |
| weight loss medication, herbal supplements? | YES | NO |
| Fen-phen, Redux, Pondimin, or other fenfluramine or dexfenfluramine related drugs? | YES | NO |
| 8. Women only. | | |
| Are you pregnant? | YES | NO |
| Are you nursing? | YES | NO |
| Taking birth control pills? | YES | NO |
| 9. Are you currently taking medications, or over-the-counter medicines? | | |
| YES | NO | |
| 10. Do you have or have you had any diseases or medical problems NOT listed on this form? | | |
| YES | NO | |

Please explain "yes" answers if needed:

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health.

Patient Name: _____ **Patient Signature / Parent if minor:** _____ **Date:** _____

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DOCTOR'S NOTES

Reviewed by Dr. _____

Date: _____