Positively PDA

Medical History Form

Name_______________________________ **Date**_______________

If you are completing this form for another person, what is your relationship to that person? _______________
For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.
* Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health since it is our top-priority.

1) Are you in good health? _ _ _ _ _ _ _ _ _ _ YES NO
2) Has there been any change in your general health within the past year? _ _ _ _ _ _ YES NO
3) My last physical examination was on the following approximate date: _______________
4) Are you now under the care of a physician? _ _ _ _ _ _ _ _ YES NO
   If so, what is the condition being treated? _______________
5) The name and address of my physician (s) is: _______________
   _______________Phone Number _______________
   _______________Phone Number _______________
6) Have you had any serious illness, operation or been hospitalized in the past 5 years? _ _ _ _ _ YES NO
   If so, what was the illness or problem? _______________
7) Are you taking any medicine (s) including non-prescription medicine? _ _ _ _ _ YES NO
   If so, what medicine(s) are you taking? (Please list and give dosage) _______________
   ____
   ____
8) Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart? _ _ _ _ YES NO
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke)? _ _ _ _ _ YES NO
      - Do you have chest pain upon exertion? _ _ _ _ _ YES NO
      - Are you ever short of breath after mild exercise or when lying down? _ _ _ _ _ YES NO
      - Do your ankles swell? _ _ _ _ _ YES NO
      - Do you have heart defects from birth? _ _ _ _ _ YES NO
      - Do you have a cardiac pacemaker? _ _ _ _ _ YES NO
   c. Allergy _ _ _ _ _ YES NO
   d. Sinus trouble _ _ _ _ _ YES NO
   e. Asthma or hay fever _ _ _ _ _ YES NO
   f. Fainting spells or seizures _ _ _ _ _ YES NO
   g. Persistent diarrhea or weight loss _ _ _ _ _ YES NO
   h. Diabetes _ _ _ _ _ YES NO
   i. Hepatitis, jaundice, liver disease _ _ _ _ _ YES NO
   j. AIDS or HIV infection _ _ _ _ _ YES NO
   k. Thyroid problems _ _ _ _ _ YES NO
   l. Respiratory problems, emphysema _ _ _ _ _ YES NO
   m. Arthritis or painful swollen joints _ _ _ _ _ YES NO
   n. Stomach ulcer or reflux _ _ _ _ _ YES NO
   o. Kidney trouble _ _ _ _ _ YES NO
   p. Tuberculosis _ _ _ _ _ YES NO
   q. Persistent cough or cough produces blood _ _ YES NO
   r. Persistent swollen glands in neck _ _ _ _ _ YES NO
   s. High or low blood pressure (circle which) _ _ _ YES NO
   t. Sexually transmitted disease _ _ _ _ _ YES NO
   u. Epilepsy or other neurological disease _ _ _ _ YES NO
   v. Problems with mental health _ _ _ _ _ YES NO
   w. Cancer _ _ _ _ _ YES NO
   x. Problems of the immune system _ _ _ _ _ YES NO
9) Have you ever had abnormal bleeding? _ _ _ _ _ YES NO
   a. Have you ever required a blood transfusion? _ _ _ _ _ YES NO
10) Do you have any blood disorder such as anemia? _ _ _ _ _ YES NO
11) Have you ever had any treatment for a tumor or growth? _ _ _ _ _ YES NO
12) Have you ever had an adverse, allergic-type reaction to:
   a. Local anesthetics _ _ _ _ _ YES NO
   b. Penicillin/ other antibiotics _ _ _ _ _ YES NO
   c. Sulfa drugs _ _ _ _ _ YES NO
   d. Barbiturates, sleeping pills _ _ _ _ _ YES NO
   e. Aspirin _ _ _ _ _ YES NO
   f. Iodine _ _ _ _ _ YES NO
   g. Codeine or other narcotics _ _ _ _ _ YES NO
   h. Other _ _ _ _ _ YES NO
13) Have you ever had any serious trouble associated with previous dental treatment? _ _ _ _ _ YES NO
   If so, explain: _______________
14) Do you have any disease, condition or problem not listed above? _ _ _ _ _ YES NO
   If so, explain: _______________
15) Do you have an artificial joint? YES NO If so, which one and when: _______________
16) Are you pregnant? _ _ _ _ _ YES NO
17) Do you have any problems associated with your menstrual period? _ _ _ _ _ YES NO
18) Are you nursing? _ _ _ _ _ YES NO
19) Are you taking birth control pills? (Be aware that antibiotics can decrease their efficacy.) _ _ _ _ _ YES NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

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Signature of patient or guardian