MEDICAL HISTORY

T. Daniel Haeussner, DMD

Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Are you under a physician's care now? ☐ Yes ☐ No If so, for what? _____

Physician's Name _____ Phone # (_____) _____

Are you taking (or supposed to be taking) any medications, vitamins or herbal supplements? ☐ Yes ☐ No Please list:

Have you taken the drug Phen-fen? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Have you taken Cortisone or other steroids in the past 12 months? ☐ Yes ☐ No

Have you taken or are you currently taking Zometa, Fosamax, Aredia, or Actonel? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No Do you have any digestive problems? ☐ Yes ☐ No

Do you use tobacco in any form? ☐ Yes ☐ No _____

Are you allergic to any medications or substances? If so, please check boxes below.

☐ Aspirin ☐ Penicillin or Other Antibiotics ☐ Sulfa Drugs ☐ Codeine
☐ Acrylic ☐ Any Metals ☐ Latex or Rubber ☐ Anesthetics such as Novocaine
☐ Iodine ☐ Other _____

Have you ever had a reaction or experienced complications to any dental treatment in the past? ☐ Yes ☐ No

Have you ever been required to pre-medicate with antibiotics prior to receiving dental treatment? ☐ Yes ☐ No

Have you had in the past or have presently any of the following conditions:

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Lung or Breathing Problems	☐	☐	Severe Headaches	☐	☐
Heart Murmur*	☐	☐	Shortness of Breath	☐	☐	Fainting or Dizzy Spells	☐	☐
Irregular Heart Beat	☐	☐	Sinus Trouble	☐	☐	Epilepsy, Seizures or Convulsions	☐	☐
Angina or Chest Pain	☐	☐	Asthma	☐	☐	Psychiatric Care	☐	☐
Heart Attack or Failure	☐	☐	Chronic Cough	☐	☐	Hepatitis	☐	☐
Congenital Heart Disorder	☐	☐	Emphysema	☐	☐	Jaundice or Liver disease	☐	☐
Mitral Valve Prolapse*	☐	☐	Tuberculosis (TB)	☐	☐	Arthritis, Gout or Rheumatism	☐	☐
Rheumatic Fever*	☐	☐	Frequent Sore Throat	☐	☐	Artificial Joint*	☐	☐
Artificial Heart Valve*	☐	☐	Tumor or Cancer	☐	☐	Stomach or Intestinal Disease	☐	☐
Heart Pacemaker*	☐	☐	X-ray or Cobalt Treatment	☐	☐	Thyroid Disease	☐	☐
Heart Surgery	☐	☐	Chemotherapy	☐	☐	Kidney or Bladder Problems	☐	☐
Stroke	☐	☐	Enlarged Lymph Nodes (Glands)	☐	☐	Renal Dialysis	☐	☐
Aneurysm	☐	☐	Swelling of Limbs	☐	☐	Hypoglycemia	☐	☐
High Blood Pressure	☐	☐	Bruise Easily	☐	☐	Frequent Diarrhea	☐	☐
Low Blood Pressure	☐	☐	HIV Positive or AIDS	☐	☐	Glaucoma or Eye Problems	☐	☐
Bleeding Disorder	☐	☐	Sexually Transmitted Diseases	☐	☐	Excessive Thirst	☐	☐
Blood Transfusion	☐	☐	Major surgery	☐	☐	Diabetes	☐	☐

Have you ever had any other disease, problem or condition not listed above? ☐ Yes ☐ No Discuss _____

_____

Do you wish to speak privately to the dentist about any problems? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____

NEW PATIENT REFERRAL INFORMATION

Who may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice: _____