CrossPointe DENTAL

BRILLIANT DENTISTRY. BRILLIANT SMILES.

# MEDICAL HISTORY

**Patient Name:**_____ **Date of Birth:**_____

**Physician's Name**_____ **Physician's Phone**_____

Please check the box for any condition which you have had in the past or have now. Parents or Guardian, if you are completing this form for your child, please indicate your child's health status by checking the appropriate boxes.

**CARDIOVASCULAR**
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Angina or Chest Pain
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Congenital Heart Defect
- ☐ Artificial Heart Valve
- ☐ Have Taken Phen-Fen
- ☐ Arrhythmias
- ☐ Heart Pacemaker
- ☐ Coronary By-Pass/Angioplasty
- ☐ Heart Transplant
- ☐ Aneurysm
- ☐ Other Heart Problem _____

**PULMONARY**
- ☐ Sinus Trouble /Hay Fever
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Tuberculosis (TB)
- ☐ Breathing Difficulties

**ALLERGIES**
- ☐ Allergy to Local Anesthetic
- ☐ Allergy to Latex (Rubber)
- ☐ Allergies or Hives
- ☐ Aspirin Allergy
- ☐ Acetaminophen Allergy
- ☐ Ibuprofen Allergy
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Allergy _____

**ENDOCRINE / NEUROLOGIC**
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Taking any Steroid
- ☐ Vision Problems
- ☐ Glaucoma
- ☐ Earaches, Ringing in Ears
- ☐ Severe Headaches
- ☐ Fainting or Dizzy Spells
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Psychiatric Treatment
- ☐ Nervous Disorders
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Head Injuries
- ☐ Alzheimer's

**GASTROINTESTINAL**
- ☐ Stomach/ Intestinal
- ☐ Persistent Diarrhea
- ☐ Eating Disorders
- ☐ Ulcers
- ☐ Colitis
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Cirrhosis

**DERMAL / MUSCULOSKELETAL**
- ☐ Skin Rash
- ☐ Changes in dark mole appearance
- ☐ Night Sweats
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus
- ☐ Artificial (Prosthetic) Joint

**HEMATOLOGIC**
- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Sickle Cell Anemia
- ☐ Prolonged Bleeding

**GENITOURINARY**
- ☐ AIDS / HIV Positive
- ☐ Urinate Frequently
- ☐ Kidney, Bladder Problem
- ☐ Kidney Disease
- ☐ Kidney Transplant
- ☐ Dialysis
- ☐ Sexually Transmitted Disease (Syphilis, Gonorrhea, Chlamydia or Genital Herpes)

**LIFESTYLES**
- ☐ Use Tobacco
- ☐ Use Alcohol
- ☐ Use of Recreational Drugs
- ☐ Drug or Alcohol Addiction (Recovering or Current)

**OTHER CONDITIONS**
- ☐ Currently Pregnant
- ☐ Due Date _____
- ☐ Nursing
- ☐ Frequent Sore Throats
- ☐ Enlarged Lymph Node or "Gland"
- ☐ Tumor or Cancer
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Other Condition Not Listed

_____

_____

_____

**FOR OFFICE USE ONLY -- MEDICAL HISTORY ANNUAL REVIEW & DATE TRACKING**

| | | |
|---|---|---|
| **Med. Hx Review Date** _____ | **Med. Hx Review Date** _____ | **Med. Hx Review Date** _____ |
| **Med. Hx Review Date** _____ | **Med. Hx Review Date** _____ | **Med. Hx Review Date** _____ |

CrossPointe DENTAL

BRILLIANT DENTISTRY. BRILLIANT SMILES.

**PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE.**

1. YES NO Do you bleed or bruise easily?
2. YES NO Have you ever taken Phen-Fen or similar appetite suppressants?

   YES NO If YES, have you seen your physician or cardiologist for a cardiac evaluation?
3. YES NO Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?
4. YES NO Are you subject to fainting?
5. YES NO Do your ankles swell during the day?
6. YES NO Have you unintentionally lost or gained more than 10 pounds in the past year?
7. YES NO Have you ever had a nervous breakdown or undergone psychiatric treatment?
8. YES NO Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
9. YES NO When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired
10. YES NO Have you been under a physicians care, admitted to a hospital or needed emergency care during the past two years?

    Describe the situation and any complications. _____
11. YES NO Have you ever had any operations or surgeries?

    Please describe the surgery. _____
12. YES NO Have you ever had any severe reaction to any dental treatment or local anesthetics?
13. YES NO Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?
14. YES NO Do you take any medications, including birth control pills?

    Please specify name and purpose of medications. _____

    _____

    _____

    _____

**I certify that the answers to the health questions are accurate and correct to the best of my knowledge.**

**Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes in my health status at any subsequent appointments.**

_____ _____

**Signature of patient or responsible party** **If responsible agent, relationship to patient**

_____

**Date**