Time 11:38 AM | VERNON L. SHEEN, D.M.D., PA | Date 2/10/2015

Medical History Form (REVISED)

Patient Name: | Birth Date: | Date Created:

GENERAL INFORMATION

Name of Physician/ and their specialty:

Most recent Physical Examination: Date/Purpose

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

ALLERGIES

DO YOU HAVE AN ALLERGY TO HAVE YOU HAD AN ALLERGIC REACTION TO:

Aspirin	Yes No	Ibuprofen	Yes No	Acetaminophen/Tylenol	Yes No	Codeine	Yes No
Penicillin	Yes No	Erythromycin	Yes No	Tetracycline	Yes No	Sulfa / Sulfa Drugs	Yes No
Local Anesthetic	Yes No	Fluoride	Yes No	Metals (Nickel, Gold, Silver, Other ____	Yes No	Latex	Yes No

Other allergy not listed above:

HEALTH QUESTIONS

DO YOU HAVE OR HAVE YOU EVER HAD:

Hospitalized for Illness or Injury	Yes No	Heart problems or Cardiac Stent last 6 m	Yes No	History of Infective Endocarditis	Yes No	Artificial Heart Valve, Repaired Heart D	Yes No
Pacemaker/ Implantable Defibrillator	Yes No	Artificial Prosthesis (heart valve/ join	Yes No	Rheumatic Fever	Yes No	Scarlet Fever	Yes No
High Blood Pressure	Yes No	Stroke	Yes No	Anemia / Other Blood Disorder	Yes No	Prolonged Bleeding	Yes No
Emphysema / Sarcoidosis	Yes No	Shortness of Breath	Yes No	Tuberculosis	Yes No	Measles	Yes No
Chicken Pox	Yes No	Asthma	Yes No	Breathing Problems	Yes No	Sleep Apnea or Snoring	Yes No
Sinus Problems	Yes No	Kidney Disease	Yes No	Liver Disease	Yes No	Jaundice	Yes No
Thyroid or Parathyroid Disease	Yes No	Calcium Deficiency	Yes No	Hormone Deficiency	Yes No	High Cholesterol	Yes No
Diabetes (HbA1c= _____)	Yes No	Stomach or Duodenal Ulcer	Yes No	Digestive Disorders i.e. Celiac or Gastr	Yes No	Osteopenia/Osteoporosis	Yes No
Arthritis/Gout	Yes No	Rheumatoid Arthritis	Yes No	Lupus	Yes No	Glaucoma	Yes No
Contact Lenses	Yes No	Head or Neck Injuries	Yes No	Epilepsy (convulsions or seizures)	Yes No	Neurologic Disorders (ADD, ADHD, Prion D	Yes No
Viral Infections or Cold Sores	Yes No	Lumps or Swelling in the mouth	Yes No	Hives, Skin Rash, Hay fever	Yes No	STI / STD	Yes No
Hepatitis (Type ____)	Yes No	HIV/AIDS	Yes No	Tumor, Abnormal Growth	Yes No	Radiation Therapy	Yes No
Chemotherapy	Yes No	Emotional Problems	Yes No	Psychiatric Treatment	Yes No	Antidepressant Medication	Yes No
Alcohol Use	Yes No	Low Blood Pressure	Yes No	Recreational Drug Use	Yes No	Drug Addiction	Yes No
Congenital Heart Disorder	Yes No	Mitral Valve Prolapse	Yes No	Heart Murmur	Yes No		

ARE YOU CURRENTLY:

Being treated for any other illness	Yes No	Aware of Changes in your health in the l	Yes No	Taking medication for weight management	Yes No	Taking Dietary Supplements	Yes No
Exhausted or Fatigued	Yes No	Experiencing Frequent Headaches	Yes No	A smoker / Using Smokeless Tobacco	Yes No	Often unhappy or depressed	Yes No
FEMALE - Taking Birth Control	Yes No	FEMALE - Pregnant	Yes No	MALE - Prostrate Disorders	Yes No	A Former Smoker	Yes No
Taking a Blood Thinner	Yes No	Taking Statin Drugs	Yes No	Taking Bisphosphonates?	Yes No		

MEDICATIONS

Please list all medications, supplements and/or vitamins taken within the last two years (Name of Medication and Purpose) on form provided.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status or medications.

Signature of Patient, Parent or Guardian:

X Date:_____