East Main Dental Center, LLP

DR GREGORY PEARSON
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MEDICAL HISTORY

PATIENT _____ DATE _____ BIRTHDATE _____

PATIENT ADDRESS _____ PATIENT PHONE _____

EMERGENCY CONTACT _____ PHONE _____

NAME OF PHYSICIAN _____ PHONE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO

FOR WHAT?

_____

_____

_____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD

ANY MAJOR OPERATIONS? YES NO

FOR WHAT?

_____

_____

_____

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY YES NO WHERE/WHEN _____

HAVE YOU HAD A HIP OR JOINT REPLACEMENT? YES NO WHERE/WHEN_____

ARE YOU TAKING ANY MEDICATIONS, PILLS, OR

DRUGS (Ex: birth control, hormone, diet) YES NO

LIST NAME AND DOSAGE:

_____

_____

_____

_____

PLEASE PROVIDE AN UPDATED MEDICATION LIST AT EVERY APPOINTMENT. IF NOT ENOUGH ROOM PROVIDED PLEASE GIVE US A LIST TO COPY.

ARE YOU TAKING ANY BLOOD THINNERS? YES NO IF YES, WHICH ONE_____

(Warfarin, Coumadin, Pradaxa, Eliquis..etc)

HAVE YOU TAKEN BONE REPLACEMENT THERAPY MEDICATIONS

KNOWN AS BISPHOSPHONATES? (fosamax, boniva..etc) YES NO IV/PILL _____

ARE YOU ON A SPECIAL DIET? YES NO IF SO WHICH_____

DO YOU USE TOBACCO (including smokeless/e-cig) YES NO

DO YOU HAVE A HISTORY OF CONTROLLED

SUBSTANCE USE YES NO

DO YOU CURRENTLY USE CONTROLLED SUBSTANCES

(including marijuana medically or recreationally) YES NO IF SO, WHAT_____

DO YOU SUFFER FROM DRY MOUTH AND/OR

EVER BEEN DIAGNOSED W/ SJOGREN'S SYNDROME YES NO IF SO, WHICH_____

HAVE YOU EVER BEEN DIAGNOSED W/ ENDOCARDITIS,

HAD MITRAL VALVE REPLACEMENT, OR RHEUMATIC FEVER YES NO IF SO, WHICH_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Aspirin Penicillin Codeine Local Anesthetic Acrylic Metal Jewelry

Sulfa Drugs Latex Other IF YES, PLEASE EXPLAIN: _____

DO YOU SNORE OR HAVE BEEN TOLD YOU SNORE? YES NO

DO YOU USE A CPAP MACHINE OR SLEEP APPLIANCE OF ANY KIND? YES NO IF SO, WHICH_____

HAVE YOU HAD THE HPV VACCINATION YES NO

WOMEN: ARE YOU

PREGNANT/TRYING TO GET PREGNANT? YES NO

TAKING ORAL CONTRACEPTIVES YES NO

NURSING YES NO

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV+	Y	N	Epilepsy or Seizures	Y	N	Malignant Hyperthermia	Y	N
Alzheimer's Disease	Y	N	Excessive Bleeding	Y	N	Mitral Valve Prolapse	Y	N
Anaphylaxis	Y	N	Excessive Thirst	Y	N	Osteoporosis	Y	N
Anemia	Y	N	Fainting spells/Dizziness	Y	N	Pain in Jaw Joints	Y	N
Angina	Y	N	Frequent Cough	Y	N	Parathyroid Disease	Y	N
Arthritis/Gout	Y	N	Frequent Headaches	Y	N	Psychiatric Care	Y	N
Artificial Heart Valve	Y	N	Glaucoma	Y	N	Radiation Treatments	Y	N
Artificial Joint	Y	N	Hay Fever	Y	N	Recent Weight Loss	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Renal Dialysis	Y	N
Blood Disease/ Bleeding disorder	Y	N	Heart Pacemaker	Y	N	Rheumatic Fever	Y	N
Breathing Problems	Y	N	Heart trouble/Disease	Y	N	Rheumatism	Y	N
Bruise Easily	Y	N	Hemophilia	Y	N	Scarlet Fever	Y	N
Cancer	Y	N	HPV	Y	N	Sickle Cell Disease	Y	N
Chemotherapy	Y	N	Hepatitis B or C	Y	N	Sinus Trouble	Y	N
Chest Pain	Y	N	High Blood Pressure	Y	N	Stomach/Intestinal Disease	Y	N
Cold sores	Y	N	High Cholesterol	Y	N	Stroke	Y	N
Congenital Heart Disease	Y	N	Hives or Rash	Y	N	Swelling of Limbs	Y	N
Cortisone Medication	Y	N	Hypoglycemia	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Irregular Heartbeat	Y	N	Tonsillitis	Y	N
Drug Addiction	Y	N	Kidney Problems	Y	N	Tuberculosis	Y	N
Emphysema	Y	N	Leukemia	Y	N	Tumors	Y	N
			Liver Disease	Y	N	Ulcers	Y	N

COMMENTS:

_____

_____

_____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE_____