Catlett Family Dentistry Medical History

Patient Name: _____ Birth Date _____ Today's Date _____

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Medical Physician's Information

Name: _____

Phone Number: _____

Are you under a physician's care now?	☐ Yes	☐ No	If yes
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes
Have you used controlled substances?	☐ Yes	☐ No	If yes
Do you need to take an antibiotic/premed prior to dental treatment?	☐ Yes	☐ No	If yes
Are you on a special diet?	☐ Yes	☐ No	If yes
Do you snore or have you ever been told you have sleep apnea?	☐ Yes	☐ No	If yes

Tobacco

Have you ever used any of the following tobacco products? ☐ No to all

☐ Cigarettes ☐ Chewing Tobacco ☐ E-Cigs/Vapors

Do you currently still use them? ☐ Yes ☐ No

Women Only

Are you any of the following? ☐ No to all

☐ Pregnant/Trying to Get Pregnant ☐ Nursing ☐ Taking Birth Control Pills

Allergies

Are you allergic to any of the following? ☐ No to all

☐ Aspirin ☐ Acrylic ☐ Sulfa Drugs

☐ Penicillin ☐ Codeine ☐ Metal

☐ Latex ☐ Local Anesthetic ☐ Peanuts

Other? ☐ Yes ☐ No If yes

Do you have, or have you had, any of the following? ☐ No to all

☐ Aids/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma- Inhaler Needed? Yes/No
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Yellow Jaundice
☐ Cortisone Medicine
☐ Diabetes -Type I or Type II
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney/Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillities
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease

Have you ever had a serious illness not listed ☐ Yes ☐ No If yes

Additional 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: _____