GULFSIDE DENTAL

Name: _____

Medical History

Date of Birth: _____

Although dentists treat diseases of the mouth, the mouth is a part of your body. Health problems you may have and medications you may take can have a large impact on dental treatment and outcomes. Thank you for answering the following questions.

Medications you are taking: _____

_____

Do you have allergies to the following? Aspirin □ Penicillin □ Codeine □ Local Anesthetic □ Acrylic □ Metal □ Latex □ Other_____

Do you have or have you had any of the following? Please circle Yes or No (Y/N)

High/Low Blood Pressure	Y	N	High Cholesterol	Y	N	Swelling of extremities	Y	N
Blood Disorders	Y	N	Anemia	Y	N	Rheumatic Fever	Y	N
Blood Transfusion	Y	N	Fainting or Dizziness	Y	N	Tuberculosis	Y	N
Asthma	Y	N	Excessive Bleeding	Y	N	Cancer	Y	N
Chronic cough	Y	N	Joint Replacement	Y	N	Chemo/Radiation	Y	N
Respiratory Issues	Y	N	Diabetes	Y	N	Chicken Pox/Shingles	Y	N
Shortness of Breath	Y	N	Kidney Problems	Y	N	Glaucoma	Y	N
Pacemaker	Y	N	Arthritis/Rheumatism	Y	N	Thyroid/Parathyroid Issue	Y	N
Artificial Heart Valve	Y	N	Alzheimer's/Dementia	Y	N	Jaundice	Y	N
Osteoporosis	Y	N	Ulcers	Y	N	Itching/hives	Y	N
Heart Attack	Y	N	Sinus Problems	Y	N	Hepatitis A, B, C	Y	N
Irregular Heartbeat	Y	N	Pain in Jaw	Y	N	HIV/AIDS	Y	N
Heart Disease	Y	N	Frequent Headaches	Y	N	Addiction to Drugs	Y	N
Angina (chest pain)	Y	N	Tonsillitis	Y	N	Psychiatric Care	Y	N
Epilepsy	Y	N	Herpes/Fever Blisters	Y	N	Anaphylaxis	Y	N

Have you had any other illness/injury not listed? Please explain _____

_____

Do you smoke? _____ How many years? _____ How much each day? _____

Has your doctor asked you to take antibiotic medications prior to dental appointments? **Y / N** Why? _____

Do you have a regular physician? **Y/N** Name: _____ Ph #: _____

For Women: Are you pregnant? **Y/N** Breast Feeding? **Y/N** Taking Birth Control? **Y/ N**

Have you taken Fosamax, Actonel, Boniva, Prolea or other drug for your bones? **Y/N** For how long? _____

To the best of my knowledge, the answers to these questions are correct. I understand that any incorrect information can be dangerous to my (or the patients') health. It is my responsibility to let the office Gulfside Dental know of any changes in my medical history. I do authorize and give consent to administer treatment, including local anesthesia, and other such treatment which may be necessary.

Signature of Patient/ Parent or Guardian_____ Date _____