LSU FACULTY DENTAL PRACTICE

MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health?.....Yes No
2. Has there been any change in your health in the past year?.....Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician?.....Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years?.....Yes No
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills?.....Yes No
   If so, please list:_____
8. Do you use any tobacco products?……..Yes No
   If so, what kind and how often?_____
   Are you interested in a smoking cessation program? ……..Yes No
9. Do you drink alcohol?.....Yes No
   If so, how many drinks per week?_____
10. Do you use any recreational drugs?.....Yes No
11. Do you have or have you had any of the following diseases or problems?

Damaged heart valves, artificial valves, heart murmur or pacemaker	Y	N	Hepatitis, jaundice or liver disease	Y	N
Rheumatic heart disease	Y	N	Frequent or recurring mouth sores	Y	N
Heart trouble, heart attack, angina , arteriosclerosis or any other heart condition	Y	N	Thyroid problems	Y	N
Chest pain upon exertion	Y	N	Respiratory problems, emphysema, bronchitis, etc	Y	N
Shortness of breath after mild exercise	Y	N	Stroke	Y	N
Do your ankles swell	Y	N	Stomach ulcer or hyperacidity	Y	N
Allergies	Y	N	Kidney trouble	Y	N
Sinus trouble	Y	N	Tuberculosis	Y	N
Asthma or hay fever	Y	N	Persistent cough or cough that produces blood	Y	N
Fainting spells or seizures	Y	N	Persistent swollen neck glands	Y	N
Diabetes	Y	N	High or Low blood pressure	Y	N
Cancer	Y	N	Epilepsy or neurological disorder	Y	N
Any disease, drug or transplant operation that has depressed your immune system	Y	N	Arthritis; Painful, swollen joints including jaw joint (TMJ)	Y	N

12. Have you had abnormal bleeding?.....Yes No
    a. Have you ever required a blood transfusion?.....Yes No
13. Do you have any blood disorder such as anemia? .....Yes No
14. Have you ever had treatment for a tumor or growth? .....Yes No

15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other ..... Yes No

16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
18. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel for osteoporosis, chemotherapy for multiple myeloma, etc.) ? ..... Yes No
19. Are you wearing removable dental appliances? ..... Yes No
20. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women:

21. Are you pregnant or trying to become pregnant? ..... Yes No
22. Are you nursing? ..... Yes No
23. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint: _____
_____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient's Signature: _____

Office Use

Medical History Update:

Date	Comments	Signature