Amy Norman DDS PS

EXCEPTIONAL COSMETIC AND ADULT DENTISTRY

MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: _____ Sex: M / F

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

1. Are you in good health? Y N
2. Has there been any change in your health in the past year? Y N
3. My last physical exam was on _____
4. Are you now under the care of a physician? Y N
   If so for what condition? _____
5. Name of Physician _____
   Address _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? Y N
7. Are you taking medicine(s) including non-prescription, homeopathic, or "natural" remedies including diet pills? Y N
   If so please list _____
8. Do you require pre-medication with antibiotics prior to dental appointments? Y N
9. Do you have or have you had any of the following diseases or problems? Y N
   a. Damaged heart valves, artificial valves, heart murmur Y N
   b. Rheumatic Fever Y N
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, or any other heart condition Y N
      1. Chest pain upon exertion? Y N
      2. Shortness of breath after mild exercise? Y N
      3. Do your ankles swell? Y N
      4. Do you have a pacemaker? Y N
      5. Do you have any pins/plates, artificial joints, or shunts placed? Y N
         If yes, when? _____
         Physician: _____
         Phone: _____
   d. Seasonal allergies/ Hives Y N
   e. Sinus trouble Y N
   f. Asthma or hay fever Y N
   g. Fainting spells or seizures Y N
   h. Diabetes Y N
   i. Hepatitis, jaundice or liver disease Y N
   j. Frequent or recurring mouth sores Y N
   k. Thyroid problems Y N
   l. Respiratory problems, emphysema, bronchitis, etc Y N
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) Y N
   n. Stomach ulcer or hyperacidity Y N
   o. Kidney trouble Y N
   p. Tuberculosis Y N
   q. Persistent cough or cough that produces blood Y N
   r. Persistent swollen neck glands Y N
   s. Low blood pressure or high blood pressure Y N
   t. Epilepsy or neurological disorder Y N
   u. Cancer Y N
   v. Any disease, drug or transplant operation that has depressed your immune system Y N
10. Have you had abnormal bleeding? Y N
    a. Have you ever required a blood transfusion? Y N
11. Do you have any blood disorder such as anemia? Y N
12. Have you ever had treatment for a tumor or growth? Y N
    If yes, what type of treatment _____
13. Are you allergic to or have you had a reaction to:
    a. Local anesthetics Y N
    b. Penicillin or antibiotics Y N
    c. Sulfa drugs or sulfide Y N
    d. Barbiturates or sleeping pills Y N
    e. Aspirin Y N
    f. Iodine Y N
    g. Codeine or other narcotics Y N
    h. Latex or rubber products Y N
    i. Other Y N
    If yes please describe your symptoms/ reaction _____
14. Have you had any serious trouble associated with previous dental treatment? Y N
15. Do you have any other condition or disease you think the doctor should know about? Y N
16. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis, chemotherapy or multiple myeloma, etc.)? Y N
17. Are you wearing contact lenses? Y N
18. Are you wearing removable dental appliances? Y N
19. Do you wish to talk with the doctor privately about anything? Y N
20. Do you smoke? Have you smoked or chewed tobacco? Y N
21. Have you had treatment for drug or alcohol abuse? Y N
22. Do you eat (drink) grapefruit (juice)? Y N
23. Do you have or have you had any of the following symptoms:
    a. Headaches or migraines Y N
    b. Facial pain Y N
    c. Neck/ shoulder pain Y N
    d. Tinnitus/ Ringing in the ears Y N
    e. Worn or cracked teeth Y N
    f. Unexplained loose teeth Y N
    g. Sensitive or sore teeth Y N
    h. Jaw Pain Y N
    i. Numbness in fingers or arm Y N
    j. Clicking or popping in the jaw joints Y N
    k. Limited jaw movement or locking jaw Y N
24. Have you had your tonsils removed? If yes, age _____ Y N
25. Have you ever had a sleep study or a CPAP? Y N
26. Have you ever had botox? Y N

WOMEN:

27. Are you pregnant or trying to become pregnant? Y N
28. Are you nursing? Y N
29. Are you taking birth control pills? Y N

Fully Explain any answered "Yes" above _____

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 have made in the completion of this form.

Date: _____ Patients Signature: _____ Reviewed by: _____ Updated: _____