Amy Norman DDS

MEDICAL HISTORY

EXCEPTIONAL COSMETIC AND ADULT DENTISTRY

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: _____

AMY NORMAN DDS

Patient Name: _____ Date: _____

Please list all Doctors:

Name and Specialty	Location	Phone Number

Pharmacy Name	Phone Number

Please list all Medications you are taking (include Prescriptions, Over-the-Counter, Vitamins and Herbal Supplements):

Drug Name	Dosage (how much)	Frequency (how often)	Taking For:

Please list any allergic reactions:

Drug Name	Reaction (did it make you sick, have a rash, difficulty breathing....)

Request additional pages if necessary and whenever list changes. Thank you for taking the time to accurately complete this form, it will help us to provide you with our very best care.