HEALTH INFORMATION

Patient Name _____ Date _____

Medical Doctor's name _____ Telephone number _____

Medical Doctor's address _____

Are you presently under the care of a medical doctor? ❑ yes ❑no

If yes, why? _____

Please list all medications you are ***taking*** including frequency and dosage _____

_____

Are you allergic or have you ever had a reaction to:

Local anesthetic	❑ yes ❑no	Penicillin	❑ yes ❑no
Codeine	❑ yes ❑no	Latex	❑ yes ❑no

Are you taking aspirin on a daily basis? ❑ yes ❑no
Are you now or have you ever been addicted to alcohol or drugs? ❑ yes ❑no
Do you have any type of artificial heart valve, joint or pin in place now, history of heart infection? ❑ yes ❑no
Have you ever been advised by a medical doctor to take an antibiotic before routine dental visits? ❑ yes ❑no

Please list any other drug or medication ***allergy*** or ***reaction***, include over-the-counter medications _____

_____

Do you have now or have you ever had:

Glaucoma	❑ yes ❑no	Kidney problems	❑ yes ❑no
Epilepsy	❑ yes ❑no	Stroke	❑ yes ❑no
Hepatitis/Liver Disease	❑ yes ❑no	Thyroid problems	❑ yes ❑no
Pain in chest	❑ yes ❑no	HIV or AIDS	❑ yes ❑no
Stomach ulcer	❑ yes ❑no	Cancer or radiation treatment	❑ yes ❑no
Excessive bleeding	❑ yes ❑no	Diabetes	❑ yes ❑no
Do you take Bisphosphonates? e.g. Fosamax, Boniva, Actonel	❑ yes ❑no	Heart disease/attack/surgery	❑ yes ❑no
		Osteoporosis	❑ yes ❑no
Do you smoke?	❑ yes ❑no	Do any of your blood relatives have diabetes ?	❑ yes ❑no
Pack/day_____ How many years_____			
Usual blood pressure_____			

Do you have any disease, condition or problem not listed? Please discuss _____

_____

WOMEN

Is there any chance you may be pregnant?	❑ yes ❑no
Are you using birth control pills or patch?	❑ yes ❑no
Have you had a hysterectomy?	❑ yes ❑no
Are you nursing?	❑ yes ❑no

Thank you for taking the time to provide this information. Thomas J. Chapman, DDS ***OVER…***