

***Precision Dental Care, LLC Medical History**

Patient Name:

Birth Date:

Date Created:

Who is your primary care physician?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have a shunt, port, valve replacement, or joint replacement?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medication, pills or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Prolia, Reclast or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you currently taking blood thinners?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you smoke or use tobacco?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you consume alcohol? If so, what is your alcohol consumption during the week?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you use controlled substances? Have you used controlled substances in the last 24hrs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Are you allergic to any of the following?

Aspirin	<input type="radio"/> Yes <input type="radio"/> No	Penicillin	<input type="radio"/> Yes <input type="radio"/> No	Codeine	<input type="radio"/> Yes <input type="radio"/> No	Acrylic	<input type="radio"/> Yes <input type="radio"/> No
Metal	<input type="radio"/> Yes <input type="radio"/> No	Latex	<input type="radio"/> Yes <input type="radio"/> No	Sulfa Drugs	<input type="radio"/> Yes <input type="radio"/> No	Local Anesthetics	<input type="radio"/> Yes <input type="radio"/> No
Other allergy?	<input type="radio"/> Yes <input type="radio"/> No			If yes	<input type="text"/>		

Sleep Apnea

Do you snore or have you been told you snore?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you been diagnosed with sleep apnea?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you had a sleep study or been told to get a sleep study?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you wear a C-PAP? Or have you worn one in the past?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you C-PAP intolerant?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Do you have, or have you had, any of the following?

High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes Type I	<input type="radio"/> Yes <input type="radio"/> No
Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Diabetes Type II	<input type="radio"/> Yes <input type="radio"/> No
Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint Replacement	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy/Seizures	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No
Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Narcolepsy	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No
Congenital Hearth Disorder	<input type="radio"/> Yes <input type="radio"/> No	Acid Reflux/GERD	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No	ADHD	<input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Depression/Anxiety	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Herpes/Cold Sores	<input type="radio"/> Yes <input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Renal Disease	<input type="radio"/> Yes <input type="radio"/> No	Periodontal Disease	<input type="radio"/> Yes <input type="radio"/> No
Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No
Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst/Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No
Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Pregnant/Nursing	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (

Signature of Patient, Parent or Guardian: _____ Date: _____