

Kuras Dental Health Associates

Medical History Form

Medical Alerts

Patient Name: _____

Date: _____

Please circle the correct answer, if you do not know the correct answer please write "UNKNOWN" on the line provided after the question.

- | | | |
|--|-----|----|
| 1. Are you under a physicians care? | YES | NO |
| Since when? _____ | | |
| Why? _____ | | |
| Name of Medical Physician: _____ | | |
| Address: _____ | | |
| Telephone: _____ | | |
| 2. When was your last complete physical exam? _____ | | |
| 3. Are you taking any medication or substances? | YES | NO |
| <i>(If yes, please provide a list of medications in the comments section at the bottom of this form.)</i> | | |
| 4. Do you routinely take health related substances? (Vitamins, Herbal Supplements) | YES | NO |
| 5. Are you allergic to any medications or substances? | YES | NO |
| <i>(If yes, please provide a list in the comments section at the bottom of this form.)</i> | | |
| 6. Do you have any other allergies or hives? | YES | NO |
| 7. Do you have any problems with penicillin, antibiotics, anesthetics, or other medications?..... | YES | NO |
| 8. Are you sensitive to any metals or latex?..... | YES | NO |
| 9. Are you pregnant or suspect you may be?..... | YES | NO |
| 10. Do you use any birth control medications?..... | YES | NO |
| 11. Have you ever been treated for or been told you might have heart disease?... | YES | NO |
| 12. Do you have a pacemaker, artificial heart valve implant, or been diagnosed with mitral valve prolapse?..... | YES | NO |
| 13. Have you ever had rheumatic fever?..... | YES | NO |
| 14. Are you aware of any heart murmurs? | YES | NO |
| 15. Do you have high blood pressure?..... | YES | NO |
| 16. Do you have low blood pressure?..... | YES | NO |
| 17. Have you ever had a serious illness or major surgery?..... | YES | NO |
| If yes, explain _____ | | |
| 18. Have you ever had radiation treatment, chemo treatment for tumor, growth, or other conditions?..... | YES | NO |
| 19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?..... | YES | NO |
| 20. Do you have inflammatory disease, such as arthritis or rheumatism?..... | YES | NO |
| 21. Do you have any artificial joints/prosthesis?..... | YES | NO |
| 22. Do you have any blood disorders, such as anemia, leukemia, etc?..... | YES | NO |
| 23. Have you ever bled excessively after being cut or injured?..... | YES | NO |
| 24. Do you have any stomach problems?..... | YES | NO |

Continued on back

