Epic Dental Associates

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Age_____

-Are you having pain or discomfort at this time?……..Yes/No
-Do you feel nervous about dental treatment?……...……Yes/No
-Have you had a bad experience in a dental office?……..Yes/No
-Have you been a patient in a hospital in the last five years?……...……Yes/No
Describe_____
-Have you been under the care of a medical doctor in the past two years?…….....……Yes/No
Describe_____
-Are you allergic to (itching, rash, swelling hands, feet or eyes) or made sick by penicillin, other antibiotics, local antibiotics, local anesthesia, sedatives, aspirin, codeine, or any drugs, metals, foods or medicines?
(Circle/describe)_____
_____
-Have you ever had excessive bleeding requiring special treatment?…….....Yes/No
-Have you ever been told by a physician or dentist that you need to be PRE MEDICATE before any dental treatment……..……Yes/No
-Are you now or have you taken any medicines, drugs or herbal products in the last two years?.....Yes/No
Describe_____
_____
-Circle any of the following that you have had or presently have:

Heart failure	**Emphysema**	**Hepatitis A (infectious)**	**Heart disease/attack**
Chronic Cough	**Hepatitis B or C (serum)**	**Angina Pectoris**	**Tuberculosis**
Liver disease	**High blood pressure**	**Yellow jaundice**	**Asthma**
Heart murmur	**Hay fever**	**Blood transfusion**	**Rheumatic fever**
Sinus trouble	**Drug/alcohol addiction**	**Damaged heart valves**	**Allergies or hives**
Hemophilia	**Scarlet fever**	**Diabetes**	**Artificial heart valve**
Thyroid disease	**Cold sores**	**Heart pacemaker**	**Radiation treatment**
Syphilis	**Heart surgery**	**Chemotherapy**	**Epilepsy or seizures**
Artificial joint	**Cancer/Tumor/Growth**	**Fainting/dizzy spells**	**Anemia**
Arthritis/rheumatism	**Nervousness**	**Stroke**	**Pain in joints**
Psychiatric treatment	**Kidney trouble**	**Glaucoma**	**Sickle cell anemia**
Ulcers	**AIDS/ HIV**	**Bruise easily**	**Presently Smoking**
Problems with immune system	**Abnormal bleeding/clotting**		

-Have you ever taken or are you taking bisphosphonates (bone density medication)……..Yes/No
-Do you have any disease, condition, or problem not listed?…….……..…...….Yes/No
Describe_____
-Do you ever wake up from sleep short of breath? ……..…….....….Yes/No
-Have you lost or gained ten or more pounds in the last year?… ..……...……..Yes/No
-Are you on any special diet? Describe……...……...……..Yes/No
-Women: Are you pregnant?…….....Yes/No Are you taking oral contraceptives?……Yes/No
-Physician of record: Date last physical:
-I understand to the best of my knowledge all answers are correct and if any changes occur I will inform the staff of Epic dental office. I understand any personal health information will only be used for treatment, payment or operational procedures according to the privacy policy of this office, a copy of which I have been given.
-I understand that appointments cancelled with less than 24 hours notice will incur a fee of $25

Patient Name_____Signature_____Date:_____
Please circle (Patient, Parent, and Guardian)

Updated_____ Updated_____
Updated_____ Updated_____
Updated_____ Updated_____