GUTTORMSEN & HOFFNER DENTAL

Medical History Form

Patient Name: **Birthdate:** **Date Created:**

MEDICAL SYMPTOMS/GENERAL

In the past 6 months, have you had any of the following?

1. Had pain or tightness in the chest? ☐ **Yes** ☐ **No**
2. Noticed a change in your vision? ☐ **Yes** ☐ **No**
3. Had a joint replacement? ☐ **Yes** ☐ **No**
4. Coughed up blood? ☐ **Yes** ☐ **No**
5. Had a cough that lasted longer than a few weeks? ☐ **Yes** ☐ **No**
6. Been exposed to anyone with tuberculosis? ☐ **Yes** ☐ **No**
7. Found it hard to catch your breath? ☐ **Yes** ☐ **No**
8. Fainted for no reason? ☐ **Yes** ☐ **No**
9. Had a heart attack? ☐ **Yes** ☐ **No**
10. Had a rapid or irregular heartbeat? ☐ **Yes** ☐ **No**
11. Had migraines or severe headaches? ☐ **Yes** ☐ **No**
12. Had a stroke or TIA? ☐ **Yes** ☐ **No**
13. Please write the name and phone number of your physician:

    _____
14. Please write the date of your last physical exam: _____
15. Have you ever had a serious illness, operation, or been hospitalized in the past 5 years? If yes, please briefly explain: _____

    _____

ALLERGIES

Are you allergic to or have you had an allergic reaction to any of the following?

Please check any/all that apply:

- ☐ Aspirin
- ☐ Iodine
- ☐ Penicillin or Amoxicillin
- ☐ Hay fever or seasonal allergies
- ☐ Augmentin
- ☐ Sulfa Drugs
- ☐ Metals
- ☐ Erythromycin
- ☐ Latex
- ☐ Codeine or Other Narcotics
- ☐ Clindamycin
- ☐ Local Anesthetics
- ☐ Barbiturate, Sedatives, or Sleeping pills

If you have an allergy to any of the above options, please briefly explain the reaction and information about your experience:

_____

_____

_____

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DIABETES

Do you have diabetes (type 1, type 2, gestational, prediabetic)? ☐ Yes ☐ No

If yes, please indicate which one: _____

Do you know your last A1C level? ☐ Yes ☐ No

If yes, please write what it is. _____

BLOOD THINNERS

Are you taking any BLOOD THINNERS? ☐ Yes ☐ No

Please check any/all that apply:

- ☐ Coumadin
- ☐ Plavix (Clopidogrel)
- ☐ Warfarin
- ☐ Heparin
- ☐ Xarelto (Rivaroxaban)
- ☐ Aspirin
- ☐ Eliquis
- ☐ Pradaxa (Dabigatran)

Are you taking any BLOOD THINNER NOT listed above? If yes, please write the name of the medication:

_____

BISPHOSPHONATES

Have you ever taken, or currently taking, any BISPHOSPHONATE medication?

☐ Yes ☐ No

Please check any/all that apply:

- ☐ Fosamax (Alendronate)
- ☐ Prolia (Denosumab)
- ☐ Actonel (Risedronate)
- ☐ Xgeva (Denosumab)
- ☐ Boniva (Ibandronate)
- ☐ Aride (Pamidronate)
- ☐ Reclast (Zolendronate)
- ☐ Zometa (Zolendronate)

1. Are you taking a BISPHOSPHONATE medication NOT listed above? If yes, please write what it is: _____
2. How was/is the BISPHOSPHONATE administered? _____
3. How long are/were you taking the BISPHOSPHONATE? _____
4. When was the last dosage of the BISPHOSPHONATE?_____

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PRESCRIPTION MEDICATIONS

Are you taking any other prescription medication not listed above? ☐ Yes ☐ No

If yes, please write the name(s):

_____

_____

_____

OTHER MEDICATIONS:

Are you taking any over-the-counter medications, supplements, herbs, and/or vitamins?

☐ Yes ☐ No

If yes, please write the name(s):

_____

_____

_____

MEDICAL AND SURGICAL HISTORY

Have you ever had any type (either total or partial) of a joint replacement surgery?

☐ Yes ☐ No

If yes, please check any/all that apply:

☐ Hip	☐ Toe	☐ Other
☐ Finger	☐ Knee	
☐ Shoulder	☐ Elbow	

Please write the date of the surgery:

_____

If you answer yes to any of the following questions, please write the date of operation and reason.

1. **Have you had a heart valve replacement? ☐ Yes ☐ No**
   Reason: _____
2. **Have you had heart surgery? ☐ Yes ☐ No**
   Reason: _____
3. **Have you had an organ transplant? ☐ Yes ☐ No**
   Reason: _____
4. **Have you had a bone marrow/stem cell transplant?** ☐ Yes ☐ No
   Reason: _____

Medical History Form

5. **Has a physician or previous dentist recommended that you take antibiotics before having dental work done? ☐ Yes ☐ No**
   Reason: _____ Name of antibiotic: _____
6. **How long are you required to take the pre-medication before dental work is completed?** _____

MEDICAL HISTORY SPECIFIC

BREATHING (RESPIRATORY) CONDITIONS

Do you have a Breathing (Respiratory) Health condition? ☐ Yes ☐ No

If yes, please select any/all that apply:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Sinus Trouble
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ COPD

If you have a Breathing (Respiratory) Health condition NOT listed above, please briefly explain:

HEART (CARDIAC) CONDITIONS

Do you have a Heart (Cardiac) Health condition? ☐ Yes ☐ No

If yes, please select any/all that apply:

- ☐ Pacemaker/ implanted defibrillator
- ☐ Heart murmur/ rhythm disorder
- ☐ Coronary artery disease
- ☐ Ateriosclerosis
- ☐ Artificial (prosthetic) heart valve
- ☐ Repaired CHD with residual defects
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Previous infective endocarditis
- ☐ Repaired (completely) CHD in the last 6 months
- ☐ Damaged heart valves
- ☐ Stroke
- ☐ Congenital Heart Disease (CHD)
- ☐ Unrepaired, cyanotic CHD
- ☐ Rheumatic heart disease
- ☐ Afib

If you have a Heart (Cardiac) Health condition NOT listed above, please briefly explain:

If you selected any condition(s) above, please write the date of diagnosis:

Medical History Form

CANCER

Do you have, or have you had, a history of cancer? ☐ Yes ☐ No

If you selected "yes" to the above question please write the date of diagnosis and type of cancer: _____

If you answered "yes" to the above questions please indicate what type of treatment was completed.

Please select any/all that apply:

☐ Surgery ☐ Radiation ☐ Chemotherapy

Please write the date of your cancer treatment:

BLOOD (CIRCULATORY) CONDITIONS

Do you have a Blood (Circulatory) Health condition? ☐ Yes ☐ No

If yes, please select any/all that apply:

☐ Anemia
☐ Hemophilia
☐ High Blood Pressure
☐ Low Blood Pressure

If you have a Blood (Circulatory) Health condition NOT listed above, please briefly explain:

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please write date of transfusion and reason:

NEUROLOGICAL DISORDERS

Do you have a Brain (Neurological)/Mental Health condition? ☐ Yes ☐ No

If yes, please select any/all that apply:

☐ Traumatic brain injury
☐ Anxiety
☐ Alzheimer's/Dementia
☐ Neurological Disorder
☐ Mental Health Disorder
☐ Post-traumatic Stress Disorder (PTSD)
☐ Concussion
☐ Depression
☐ Epilepsy

If you have a Brain (Neurological)/Mental Health condition NOT listed above, please briefly explain:

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AUTOIMMUNE DISEASES

Do you have an Autoimmune Disease? ☐ Yes ☐ No

If yes, please select any/all that apply:

- ☐ Rheumatoid Arthritis
- ☐ Sjogren
- ☐ Lupus

If you have an Autoimmune Disease NOT listed above, please briefly explain:

DIGESTIVE HEALTH CONDITIONS

Do you have a Digestive Health Condition? ☐ Yes ☐ No

If yes, please select any/all that apply:

- ☐ Gastrointestinal Disease
- ☐ G.E reflux/persistent heart burn (GERD)
- ☐ Stomach Ulcers
- ☐ Irritable Bowel Syndrome (IBS)

If you have a Digestive Health condition NOT listed above, please briefly explain:

OTHER CONDITIONS

Do you have any of the following conditions? ☐ Yes ☐ No

If yes, please select any/all that apply:

- ☐ Arthritis
- ☐ Kidney Problems
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Chronic Pain
- ☐ Immune Deficiency
- ☐ Eating Disorder
- ☐ Malnutrition
- ☐ Eye Condition
- ☐ Thyroid Disease

If you selected a condition above, please briefly explain treatment, diagnosis, and any pertinent information:

TOBACCO/NICOTINE

Do you use any form of TOBACCO or NICOTINE products? ☐ Yes ☐ No

If yes, please select any/all that apply:

- ☐ Cigarettes
- ☐ Cigars
- ☐ Snuff
- ☐ Chew
- ☐ Bids
- ☐ Vaping Products

Medical History Form

Do you use any CONTROLLED SUBSTANCES (drugs), including marijuana, for medicinal or reactional reasons? ☐ Yes ☐ No

If you answered yes to the previous question, please briefly explain:

WOMEN ONLY

1. **Are you currently taking any birth control pills?** ☐ Yes ☐ No
2. **Are you pregnant?** ☐ Yes ☐ No
    a. How many weeks? _____
3. **Are you currently nursing?** ☐ Yes ☐ No

ADDITIONAL COMMENTS:

➡**NOTE: It is important for both the doctor and the patient to talk honestly about the patient's health before dental treatment starts.**

I have answered the above questions completely, accurately, and to the best of my ability.

Patient's Signature:

X _____ **Date:**_____

FOR COMPLETION BY PROVIDER

Doctor comment: _____

Office use only:

☐ Medical Alert ☐ Allergies ☐ Nitrous

☐ Premedication ☐ Anesthetic

Reviewed by: _____

Date: _____