Mary H Makhlouf, DMD, MS, PA

MEDICAL HISTORY

Patient Name_____Birth Date_____Age:_____

Note: Although dental personnel primarily treat the area of and around your mouth, there is a lot of research showing that health problems, or medications you may be taking could have an important interrelationship with dentistry. That will affect some dental diagnoses and treatment plans. So, THANK YOU for answering the following questions accurately.

Do you have or have you had, any of the following? **Check any that apply**

__Addiction: Drug/Alcohol
__Aids/HIV positive
__Alzheimer's/Dementia
__Angina/Chest Pains
__Arthritis
__Artificial Heart Valve
__Artificial Joint
__Asthma
__Bleeding Disorder
__Bleeding Risk
__Blood Transfusion
__Bloodwork abnormalities
__Bone Disorder
__Cancer
__Car Accident
__Chemotherapy
__Cold sores/Fever blisters
__Congenital disorder
__Convulsions/Seizures/Epilepsy
__Cortisone medication
__Diabetes (A1C=)
__Emphysema
__Endocrine problems
__Fainting spells/Dizziness
__Frequent Cough
__Frequent Headaches
__Gastric Reflux
__Head or Neck Injury
__Heart attack
__Heart Disorder (born with it)
__Heart flutters/Arrhythmias
__Heart Murmur
__Heart Surgery
__Heart trouble/disease
__Hemophilia
__Hepatitis A,B,C,D,__
__Herpes
__High Blood Pressure
__Hormonal problems
__Injections to protect bone
__Jaundice
__Kidney Problems
__Liver disease
__Low Blood Pressure
__Lung Problems
__Leukemias
__Neurological Problems
__Osteoporosis
__Pain in Jaw
__Portacath
__Psychiatric Care
__Radiation Therapy
__Rheumatism
__Sexually Transmitted Disease
__Shingles
__Shortness of Breath
__Sickle Cell Disease
__Sinus Problems
__Skin Problems
__Sleep Apnea
__Stomach/Intestinal Problems
__Stroke
__Sugar high or Low
__Thyroid/Parathyroid Problems
__Tuberculosis
__Tumors/Growths
__Urology Problems
__Weight loss - rapid
__Dialysis

Name and Location of your Primary **Doctor**? _____

Do you have **other** health care **providers** or specialties caring for you? If yes, List: _____

_____

_____

Pharmacy name, location and number: _____

Have you ever been **hospitalized** or had a major operation? What/When:_____

_____

Have you ever had a **complication** to dental treatment? What/When: _____

Women: Do you have any Ob/Gyn Problems? Y N Menopause? Y N Are you:
Pregnant/Trying to ? Y N Taking oral contraceptives? Y N Nursing? Y N

Initials: *of Patient, Parent or Guardian:* ***The answers on this page are correct ____***

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Do you use **controlled substances**? Y N

Are you **Allergic** to any of the following (**hives or rash**)? Please CIRCLE if Yes:

Penicillin Codeine Sulfa Other medications: _____

Latex Acrylic Nickel Other: _____

Please list ALL your **Medications including IV, PLUS Vitamins, Supplements, Herbs** and over the counter products:

Have you **ever** been given any kind of **BONE sparing medications (Actonel, Fosamax, Boniva, Bisphosphonates, Prolia, Denosumab) ?**

Have you **ever** been given **IV medications** to help with bone cancer? Y N

Comments or **additional** Information to share:

_____

_____

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I authorize Dr. Makhlouf to clarify or expand on any medical questions with my healthcare providers. I understand that providing incorrect or incomplete information can be dangerous to my health or the health of my child or person I am signing for. It is my responsibility to inform this dental office of any changes in medical status before any upcoming visit – so Dr. Makhlouf can make any necessary adjustments to your medical/dental management. Thank you!

SIGNATURE of Patient, Parent or Guardian_____Date_____