Medical Heath History

Westford FAMILY DENTAL

Physicians name and date of last visit: _____

General:	**(please circle)**	
Have you been hospitalized in the last year?	YES	NO
Have you undergone surgery?	YES	NO
Type/year:		
_____		
_____		
Have you been diagnosed with Diabetes?	YES	NO
Type: insulin dependent: _____ non-insulin dependent: _____		
Date diagnosed: _____		
Last Blood Sugar reading: _____ Last A1C: _____		
Are you a current ***or*** former tobacco user?	YES	NO
Cigarettes: ___ Cigars: ___ Chewing Tobacco: ___ E-cigarette: ___ PIPE: ___		
How long have/had you used tobacco? _____		
Daily amount currently used: _____		
Are you interested in information to help you quit at this time?	YES	NO
Have you been diagnosed with High ***or*** low blood pressure?	YES	NO
Have you suffered a stroke?	YES	NO
If so, when? _____		
Do you have any artificial heart valves or cardiac stents?	YES	NO
Do you have a cardiac pacemaker, defibrillator, or artificial implanted device?	YES	NO
Type & year of placement: _____		
Do you have any congenital heart defects (found at birth)?	YES	NO
Have you been diagnosed with a heart murmur?	YES	NO
Have you been diagnosed with any valve prolapse?	YES	NO
Have you been diagnosed with bacterial Endocarditis?	YES	NO
Have you been diagnosed with any other cardiovascular disease?	YES	NO
Do you have any artificial joints?	YES	NO
Type: _____ Year of replacement: _____		
Have you ever been asked to take antibiotics prior to dental treatment?	YES	NO
Have you been diagnosed with Osteoporosis or osteopenia?	YES	NO
Have you ever used a bisphosphonate medication for bone density?	YES	NO
(Fosamax, Actonel, Atelvia, Didronel, Boniva?) If so, When? _____		
Have you been diagnosed with Cancer?	YES	NO
Type/year of diagnosis: _____		
Have you undergone chemotherapy?	YES	NO
Have you undergone Radiation treatment?	YES	NO
Are you still going in for follow-ups?	YES	NO
Do you have Herpes Simplex Virus I or II (cold sores)?	YES	NO
Are you interested in information regarding managing outbreaks?	YES	NO

-Questionnaire continues on next page-

Have you been diagnosed with or treated for any of the following? ***(Circle any that apply)***

Asthma
Emphysema
COPD
Abnormal bleeding/Clotting
Epilepsy or seizures
Back or neck pain
Anemia
Kidney Disease
Glaucoma
Jaundice
Liver Disease
Headaches
Rheumatic Fever
Tuberculosis
Arthritis or Rheumatism
Cortisone Treatments
HIV or AIDS
Thyroid problems
Elevated stress
Human Papilloma Virus (HPV)
Hepatitis
Type/year: _____

ALLERGIES

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetics
Penicillin
Sulfa Drugs
Metals
Other:
_____
_____
_____

MEDICATIONS

Please list any medications (including over the counter medications) that you are taking and the corresponding diagnosis

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PHARMACY NAME AND PHONE: _____

WOMEN

Are you pregnant? How many weeks: _____ YES NO
Are you nursing? YES NO
Do you currently take birth control pills? YES NO

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely. Refusal to do so may result in dismissal from the practice.

Date: _____ ***Patient Signature:*** _____