TRIAD DENTISTRY
COMPREHENSIVE DENTAL CARE

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MEDICAL HISTORY

Name of Patient: _____ **DOB:** _____

Name of Medication/Drug/Supplement & Dosage: **Purpose/Reason:**

_____ _____
_____ _____
_____ _____
_____ _____

Do you require antibiotic prophylaxis prior to dental treatment? Y N
If Yes, Why? _____ Which Antibiotic? _____

Do you have any artificial joints or prosthesis? Y N If Yes, when was surgery performed? _____

Have you had an allergic reaction to any of the following substances or other substances? Penicillin, Sulfa Drugs, Aspirin, Codeine, Morphine, Dental Anesthetic, Latex, Other. _____

_____

Other Medical Information: _____

Bisphosphonates . . . . . .
Have you ever taken bone modifying medications (such as bisphosphonates or denosumab) that affect the bone or prevent bone disease (e.g. Fosamax [Alendronic acid], Zometa [Zoledronic acid], Actonel [Risedronic acid], Boniva [Ibandronic acid], Aredia, Prolia, Xgeva? Y N

If Yes, please list the medication and how long it was or has been taken for. _____

_____

Cardiovascular . . . . . .
Do you or have you ever been told you have any of the following conditions and what date were they diagnosed?

1) Congenital Heart Problems? Y N If Yes, when was it diagnosed? _____
2) Infective Endocarditis or other Heart Infection? Y N If Yes, when was it diagnosed? _____
3) Artificial Heart Valves? Y N If Yes, when were those placed? _____
4) Heart Transplant? Y N If Yes, when was that performed? _____

Sleep Apnea / Snoring . . . . . .

1) Have you or anyone in your family been diagnosed with sleep apnea? Y N If so, who? _____

2) Do you snore or has someone told you that you snore? Y N

3) Do you gasp or have periods of breathing pauses during sleep? Y N

4) Do you have difficulty staying awake during the day or fall asleep when you should be awake? Y N

Do you have (or have you ever been told you have or had in the past) any of the following conditions?

High Blood Pressure Y N

High Cholesterol Y N

Heart Disease Y N

(e.g. angina, coronary artery disease, congenitive heart failure)

Diabetes Y N

(sugar diabetes, blood sugar problems)

Cancer/Tumors Y N

Have you ever had radiation, surgery or Chemotherapy to treat cancer? Y N

Inflammatory Diseases Y N

(e.g. arthritis, rheumatism)

Alzheimer's Disease Y N

Asthma Y N

Thyroid Problems Y N

Epilepsy or Dizzy Spells Y N

Hepatitis or other Liver Disease Y N

Herpes Y N

Tuberculosis "TB" Y N

HIV / AIDS or any other immunocompromised conditions? Y N

Blood Disorders Y N

(anemia, hemophilia, sickle cell anemia)

Kidney Problems Y N

Stomach or Intestinal Disorders Y N

(e.g. ulcers, GERD)

Phobias, Severe Anxieties, Depression or other psychological Problems) Y N

Do you use tobacco? Y N

Drug Addiction? Y N

Have you ever bled excessively after being cut or receiving dental care? Y N

Have you ever had a heart attack, stroke or coronary bypass operation? Y N

Breathing Problems? Y N

Do you have a pacemaker? Y N

Are you pregnant / think you may be? Y N

Are you nursing? Y N

Please provide details on any conditions which you responded "YES" to above: _____

_____

_____

Are there any other problems or issues about your health that you know of? If yes, please explain: ____

_____

_____

X _____ /_____ Date: _____

Signature of Patient Printed Name of Patient

Individual updating medical history if not the patient: _____