**Dr. Michael D. Levy**

**MEDICAL HISTORY**

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date Completed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you are taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you under a physician’s care? | Yes | No | If yes  |  |
| Have you ever been hospitalized or have a major operation?  | Yes | No |  |  |
| Have you ever had a serious head or neck injury? | Yes | No |  |  |
| Are you taking any medications, pills or drugs? | Yes | No |  |  |
| Do you take or have you taken Phen-Fen or Redux? | Yes | No |  |  |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  | Yes | No |  |  |
| Are you on a special diet? | Yes | No |  |  |
| Do you use tobacco? | Yes | No |  |  |
| Do you use controlled substances? | Yes | No |  |  |

WOMEN, are you. .

|  |  |  |
| --- | --- | --- |
| Pregnant /Trying to get pregnant? YES NO  |  Nursing? YES NO  | Taking Oral Contraceptives? YES NO |

Are you allergic to any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Aspirin YES NO | Penicillin YES NO | Codeine YES NO | Acrylic YES NO |
| Metal YES NO | Latex YES NO | Sulfa Drugs YES NO | Local Anesthetics YES NO |
| Other? YES NO If yes:  |

Do you have or have you had any of the following?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AIDS/HIV Positive | Yes | No | Cortisone Medicine | Yes | No | Hemophilia | Yes | No | Radiation  | Yes | No |
| Alzheimer’s Disease | Yes | No | Diabetes | Yes | No | Hepatitis A | Yes | No | Recent Weight Loss | Yes | No |
| Anaphylaxis | Yes  | No | Drug Addiction | Yes | No | Hepatitis B or C  | Yes  | No  | Renal Dialysis | Yes | No |
| Anemia | Yes | No | Easily Winded | Yes | No | Herpes | Yes | No | Rheumatic Fever | Yes | No |
| Angina | Yes | No | Emphysema | Yes | No | High Blood Pressure | Yes  | No | Rheumatism | Yes  | No |
| Arthritis/Gout | Yes | No | Epilepsy or Seizures | Yes | No | High Cholesterol | Yes | No | Scarlet Fever | Yes | No |
| Artificial Heart Valve | Yes | No | Excessive Bleeding | Yes | No | Hives or Rash | Yes | No | Shingles | Yes | No |
| Artificial Joint | Yes | No | Excessive Thirst | Yes | No | Hypoglycemia | Yes | No | Sickle Cell Disease | Yes | No |
| Asthma | Yes | No | Fainting Spells/Dizziness | Yes | No | Irregular Heartbeat | Yes | No | Sinus Trouble | Yes | No |
| Blood Disease | Yes | No | Frequent Cough | Yes  | No | Kidney Problems | Yes | No | Spina Bifida | Yes | No |
| Blood Transfusion | Yes | No | Frequent Diarrhea | Yes | No | Leukemia | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Breathing Problems | Yes | No | Frequent Headaches | Yes | No | Liver Disease | Yes | No | Stroke | Yes | No |
| Bruise Easily | Yes | No | Genital Herpes | Yes | No | Low Blood Pressure | Yes | No | Swelling of Limbs | Yes | No |
| Cancer | Yes | No | Glaucoma | Yes | No | Lung Disease | Yes | No | Thyroid Disease | Yes | No |
| Chemotherapy | Yes | No | Hay Fever | Yes | No | Mitral Valve Prolapse | Yes | No | Tonsillitis | Yes | No |
| Chest Pains | Yes | No | Heart Attack / Failure | Yes | No | Osteoporosis | Yes | No | Tuberculosis | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Heart Murmur | Yes | No | Pain in Jaw Joints | Yes | No | Tumors or Growths | Yes | No |
| Congenital Heart Disorder | Yes | No | Heart Pacemaker | Yes | No | Parathyroid Disease | Yes | No | Ulcers | Yes | No |
| Convulsions | Yes | No | Heart Trouble/Disease | Yes | No | Psychiatric Care | Yes | No | Venereal Disease | Yes | No |
| COVID 19  | Yes | No |  |  |  |  |  |  | Yellow Jaundice | Yes  | No |

Have you ever had any serious illness no listed above? YES NO If yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient’s) health. It is my responsibility to inform the dental office of any changes to my medical status.

Signature of Patient, Parent or Guadian

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_