Cliffside Park
DENTAL GROUP

Medical History

(All information will be kept confidential)

Patients Name _____ Birthday _____

Primary Care Physician _____ City _____ Phone _____

List MEDICAL SPECIALISTS you have seen:

1. Physician's Name _____ Specialty _____
2. Physician's Name _____ Specialty _____

Describe your health:

__Excellent (better than most people my age)

__Good (I am not aware of any medical problem)

__Fair (I have some health problems but they're under control)

__Guarded (I have some current health problems)

__Poor (I have some major health problems)

When was the last time you saw your physician? _____ (Year) What was the purpose? _____

Have you ever been hospitalized or had a serious illness? No__ Yes__ Describe: _____

HABITS

__N/A

__Cigarettes

__Smoked but quit. When? _____

__Currently smoking. Amount? _____ Start Date: _____

__Vape

__Cigars

__Pipe

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WOMEN

Are you pregnant? No__ Yes__, estimated due date _____

Are you nursing? No__ Yes__

Are you taking oral contraceptives? No__ Yes__

Are you undergoing hormone replacement therapy? No__ Yes__

MEDICATIONS

Are you under treatment for Osteoporosis and taking a class of medications called Biphosphonates? No__ Yes__

Some common names include: Actonel Boniva Fosamax Fosamax Plus D Other

Are you taking any blood thinner? No__ Yes__

Some common names include: Plavix Ticlid Lovanox Coumadin/Warfarin Other

ALLERGIES

Are you allergic to any of the following?

Latex / Penicillin / Sulfa / Metals / Vicodin / Percocet / Codeine / Local Anesthetic / Aspirin

NSAIDs like Motrin / Other antibiotics: _____

Name the specific medication and describe your reaction: _____

List any surgeries or major health events			Medications INCLUDING over-the-couner medications and herbal supplements		
Year	Event		Name of Medicine	Dosage	Purpose: Why are you taking it?

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HEART / VASCULAR

__Heart Attack (MI)
__Congenital heart defect
__Rheumatic Fever
__Irregular heartbeat (missed beats)
__Heart murmur
__High blood pressure
__Low blood pressure
__Angina / Chest Pain
__Mitral Valve Prolapse
__Artificial heart valve(s)
__Pacemaker
__By-pass surgery
__Stent replacement
__Congestive heart failure
__Swelling of ankles
__Shortness of breath

BLOOD

__Anemia
__Sickle cell disease
__Hemophilia
__Bruise very easily
__Prolonged bleeding
__HIV / AIDS

RESPIRATORY

__Tuberculosis
__Emphysema
__Asthma
__Persistent Cough
__Coughing up blood / sputum
__Difficulty breathing while lying down
__Winded going up a flight of stairs
__Lung cancer
__Other lung disease

BONE

__Arthritis / Rheumatism
__Osteoporosis
__Gout
__Artificial joints or limbs

URINARY

__Kidney disease
__Renal dialysis
__Frequent urination
__Burning with urination
__Blood or discharge in urine
__Venereal disease
__Genital herpes

NERVOUS SYSTEM

__Stroke (CVA) or TIA
__Severe headaches / Migraine
__Fainting or dizzy spells
__Convulsions or Epilepsy
__Numbness or tingling

ENDOCRINE

__Diabetes:
Type 1 / Type 2
__Excessive thirst
__Thyroid disease
__Hypoglycemia

MENTAL HEALTH

__Depression
__Anxiety
__Panic attacks
__Psychiatric treatment
__Bipolar (manic-depressive)
__Addictive disorders
Type: _____
__Other: _____

HEAD / NECK / EYES

__Glaucoma
__Macular Degeneration
__Loss of hearing
__Tonsillitis
__Sinus problems

DIGESTIVE SYSTEM

__Hepatitus, Type ____
__Gastric reflux
__Ulcers
__Frequent diarrhea
__Crohn's disease or colitis

CANCER

__Tumor
*Type:*_____
__Radiation treatment
__Chemotherapy
__Organ removal
Organ: _____
*Date:*_____
__Organ transplant
*Organ:*_____
*Date:*_____

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To the best of my knowledge, all of the above information is correct.

Signature: _____ Date: _____

Doctor Notes: