Malcomson DENTISTRY

Patient Medical History

Name: _____ **Approx. date of last physical:** ____/____/____

Primary Care Physician: _____ **Physician Phone Number:** (____)_____

Pharmacy, Location & Phone Number: _____ (____)_____

1. Are you currently under medical care? *If yes, please specify:* _____. Y N
2. List **ALL** medications (prescription, non-prescription, homeopathic/herbal supplements *and* recreational drugs) _____ Y N
   _____.
3. In the last 5 years, have you had surgery (i.e. cosmetic, joint, etc.), a serious illness or unexplained weight loss? *If yes, please specify:* _____. Y N
4. Have you ever taken *(circle)*: Fen-Phen / Dexfenfluramine / Bisphosphonates? Y N
5. Do you currently use (circle): chewing tobacco / smoke / smokeless products? Y N
6. **Women ONLY:** Are you pregnant, think you might be pregnant or nursing? Y N
   Are you using any form of oral or implanted contraception? Y N

Y N Allergies / Hay Fever
Y N Sinus Problems
Y N Asthma
Y N Respiratory Disease **/ COPD**
Y N Pneumocystitis
Y N Emphysema
Y N Tuberculosis
Y N Acid Reflux / Ulcer
Y N Arthritis / Rheumatism
Y N Back Problems
Y N **Osteoporosis**, please list medication:_____
Y N Cancer Treatment (circle): Chemo / Radiation Therapy
Y N Congenital Heart Defect
Y N **HIGH** Blood Pressure
Y N **LOW** Blood Pressure
Y N Fainting Spells
Y N Rheumatic Fever
Y N Anemia
Y N Abnormal Bleeding
Y N Hemophilia
Y N Blood Transfusion

Y N Artificial Bones
Y N Artificial Joint Replacement
Y N Other Implant:_____
Y N Angina Pectoris
Y N Heart Murmur
Y N Heart Attack
Y N Cardiac Incident (circle): Pacemaker / Atrial Fibrillation
Y N Artificial Heart Valve
Y N Heart Valve Replacement
Y N Mitral Valve Prolapse
Y N Stroke
Y N Circulatory Problems
Y N Edema / Swelling of Ankles or Feet
Y N Colitis / IBS
Y N Diabetes
Y N Epilepsy
Y N Seizures
Y N Contact Lenses
Y N Glaucoma
Y N Headaches / Migraines
Y N Sickle Cell Disease

Y N Kidney / Bladder Disease
Y N Liver Disease / Jaundice
Y N Shingles
Y N Cortizone / Steroid Therapy
Y N Thyroid Problems
Y N Psychiatric Care
Y N Alcohol Dependency
Y N **Drug / Substance / Chemical Dependency**
Y N Hepatitis _____
Y N STI(s): _____
Y N **Immune System Disorder: AIDS / HIV / ARC**

ALLERGIES (circle): Aspirin, Codeine, Dental Anesthetics, Erythromycin, Jewelry, Latex, Metals, Penicillin, Tetracycline, Local Anesthesia, Antibiotics, Sulfa Drugs or list other allergies: _____
_____
_____
_____

I certify to the best of my knowledge that I have honestly and accurately answered the above medical questions. I understand that providing incorrect or misinformation can be dangerous to my health. I will not hold Dr. Malcomson or any of the Malcomson Dentistry staff responsible for errors or omissions that I have made in the completion of this form.

Patient or Guardian's Signature: _____ **Date:** _____/_____/_____

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