Malcomson DENTISTRY

Patient Medical History

Patient's Name: _____ **Approx. Date of LAST Physical:** ____/____/____

Primary Care Physician: **Dr.** _____ 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 past 5 years, have you had surgery (joint, cosmetic, etc.), a serious illness or significant weight loss? *If yes, please specify:* _____	Y	N
4.	Have you ever taken *(circle)*: Fen-Phen / Dexfenfluramine / Bisphosphonates?	Y	N
5.	Do you currently *(circle)*: chew tobacco / smoke / vape / e-cigarettes?	Y	N
6.	**Women ONLY (circle):** Are you pregnant or think you may be pregnant / breast feeding?	Y	N
	Are you using any form of oral or implanted contraception?	Y	N

Check ALL applicable medical conditions:

- o Allergies / Hay Fever
- o Sinus Problems
- o Asthma
- o **Respiratory Disease / COPD**
- o **Pneumocystitis**
- o Emphysema
- o Tuberculosis
- o Acid Reflux / Ulcer
- o Arthritis / Rheumatism
- o Back Problems
- o **Osteoporosis** medication

_____

- o **Cancer Treatment: Chemo / Radiation Therapy**
- o **HIGH** Blood Pressure
- o **LOW** Blood Pressure
- o Fainting Spells
- o Rheumatic Fever
- o Anemia
- o Abnormal Bleeding
- o Hemophilia
- o Blood Transfusion
- o Artificial Bones
- o **Artificial Joint Replacement**
- o **Other Implant:**_____
- o Angina Pectoris
- o Congenital Heart Defect
- o Heart Murmur
- o Heart Attack
- o **Cardiac Incident / Pacemaker / or Atrial Fibrillation**
- o **Artificial Heart Valve**
- o Heart Valve Replacement
- o Mitral Valve Prolapse
- o Stroke
- o Circulatory Problems
- o Edema / Swelling of Ankles/Feet
- o Colitis / IBS
- o Epilepsy
- o Seizures
- o Contact Lenses
- o Glaucoma
- o Headaches / Migraines
- o Diabetes
- o Sickle Cell Disease
  Kidney / Bladder Disease
- o Liver Disease / Jaundice
- o Shingles
- o Cortizone / Steroid Therapy
- o **Thyroid Problems**
- o Psychiatric Care
- o Alcohol Dependency
- o **Drug / Substance / Chemical Dependency**
- o Hepatitis: _____
- o STI(s):_ _____
- o **Immune System Disorder: AIDS / HIV / ARC**

LIST / CIRCLE allergies:
- Antibiotics – Aspirin – Codeine - Dental Anesthetics – Erythromycin – Jewelry – Latex - Local Anesthesia – Metals – Penicillin - Sulfa drugs - - Tetracycline

_____

_____

I attest to the best of my knowledge, that I have honestly answered all medical questions, checked and listed all allergies. I understand that providing incorrect or misinformation can be dangerous to my health and Dr. E. Denise Malcomson and Malcomson Dentistry staff will not be responsible for errors and omissions that I make on this form.

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

8218 Wisconsin Avenue - Suite 415, Bethesda, Maryland 20814 O: (301) 656-1588 E: MalcomsonDentistry@gmail.com