Dicus Family Dentistry

Name: _____ Age: _____

Medical History:

Please check **YES OR NO** if you currently have, or have ever had, any of the following conditions:

AIDS/HIV Positive	[ ] Yes [ ] No	Fainting Spells/Dizziness	[ ] Yes [ ] No	Psychiatric Care	[ ] Yes [ ] No
Alzheimer's Disease	[ ] Yes [ ] No	Frequent Cough	[ ] Yes [ ] No	Radiation Treatments	[ ] Yes [ ] No
Anaphylaxis	[ ] Yes [ ] No	Frequent Headaches	[ ] Yes [ ] No	Recent Weight Loss	[ ] Yes [ ] No
Angina	[ ] Yes [ ] No	Glaucoma	[ ] Yes [ ] No	Rheumatic Fever	[ ] Yes [ ] No
Arthritis/Gout	[ ] Yes [ ] No	Heart Murmur	[ ] Yes [ ] No	Scarlet Fever	[ ] Yes [ ] No
Artificial Heart Valve	[ ] Yes [ ] No	Heart Pacemaker	[ ] Yes [ ] No	Shingles	[ ] Yes [ ] No
Artificial Joint	[ ] Yes [ ] No	Heart Trouble/Disease	[ ] Yes [ ] No	Sickle Cell Disease	[ ] Yes [ ] No
Asthma	[ ] Yes [ ] No	Hepatitis A	[ ] Yes [ ] No	Sinus Trouble	[ ] Yes [ ] No
Blood Disease/Anemia	[ ] Yes [ ] No	Hepatitis B or C	[ ] Yes [ ] No	Stomach/Intestinal Disease	[ ] Yes [ ] No
Bleeding Disorder	[ ] Yes [ ] No	High Blood Pressure	[ ] Yes [ ] No	Stroke	[ ] Yes [ ] No
Breathing Problems	[ ] Yes [ ] No	High Cholesterol	[ ] Yes [ ] No	Swelling of Limbs	[ ] Yes [ ] No
Bruise Easily	[ ] Yes [ ] No	Hives or Rash	[ ] Yes [ ] No	Thyroid Disease	[ ] Yes [ ] No
Cancer	[ ] Yes [ ] No	Irregular Heartbeat	[ ] Yes [ ] No	Tonsillitis	[ ] Yes [ ] No
Chemotherapy	[ ] Yes [ ] No	Kidney Problems/Dialysis	[ ] Yes [ ] No	Tuberculosis	[ ] Yes [ ] No
Chest Pains	[ ] Yes [ ] No	Leukemia	[ ] Yes [ ] No	Tumors or Growths	[ ] Yes [ ] No
Cold Sores/Fever Blisters	[ ] Yes [ ] No	Liver Disease	[ ] Yes [ ] No	Ulcers	[ ] Yes [ ] No
Congenital Heart Disorder	[ ] Yes [ ] No	Low Blood Pressure	[ ] Yes [ ] No	…**Women Only…**	
Cortisone Medicine	[ ] Yes [ ] No	Lung Disease	[ ] Yes [ ] No	Are you pregnant	[ ] Yes [ ] No
Diabetes (HbA1c= ____)	[ ] Yes [ ] No	Mitral Valve Prolapse	[ ] Yes [ ] No	Trying to get pregnant	[ ] Yes [ ] No
Easily Winded	[ ] Yes [ ] No	Osteoporosis/Osteopenia	[ ] Yes [ ] No	Nursing	[ ] Yes [ ] No
Emphysema	[ ] Yes [ ] No	-Taking Bisphosphonates	[ ] Yes [ ] No	Taking oral contraceptives	[ ] Yes [ ] No
Epilepsy or Seizures	[ ] Yes [ ] No	Pain in Jaw Joints	[ ] Yes [ ] No		
Excessive Thirst	[ ] Yes [ ] No	Parathyroid Disease	[ ] Yes [ ] No		

Are you allergic to any of the following?

[ ] Aspirin [ ] Ibuprofen [ ] Penicillin [ ] Codeine [ ] Sulfa [ ] Local Anesthetic
[ ] Latex [ ] Acrylic [ ] Metal [ ] Other _____

Please list any additional health problems:_____

Please list surgeries/hospitalization stays you've had:_____
_____

Social History: Do you use tobacco? [ ] current or [ ] past Alcohol? [ ] current or [ ] past

If so, indicate type, frequency and for how many years: _____

Please list any medications, supplements, and or vitamins taken within the last two years and the purpose for them.

_____ _____ _____
_____ _____ _____
_____ _____ _____

I have completed this form to the best of my knowledge. I give Dr. Michael T. Dicus and employees of Dicus Family Dentistry permission to take any necessary diagnostic x-rays, photos, or study models required to enable complete diagnosis and treatment.

Signature: _____ Date: _____
(Patient, parent or legal guardian)