Bushnell Family & Cosmetic Dentistry

Sumter Value Dental

Medical Health History

Patient's Name (Please Print) _____ Date of Birth _____ Date _____

(Circle Answers)

1. Are you in good health Y N
2. Any change in your general health in the past year? Y N
3. Date of last physical exam _____
4. Are you now under a physician's care? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe _____
   _____
6. Do you have or have you ever had:
   A. Rheumatic Fever or Rheumatic Heart Disease Y N
   B. Congenital Heart Disease Y N
   C. Cardiovascular Disease (heart attack, heart trouble, heart murmur, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker) Y N
   D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing) Y N
   E. Seizures, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other nervous disorder. Y N
   F. Bleeding disorder, anemia, blood transfusion Y N
   G. Liver Disease (jaundice, hepatitis) Y N
   H. Kidney Disease Y N
   I. Diabetes Y N
   J. Thyroid disease (goiter) Y N
   K. Arthritis Y N
   L. Stomach Ulcers or Colitis Y N
   M. Glaucoma Y N
   N. Implants (heart valve, pacemaker, hip, knee) Y N
   O. Radiation treatment for cancer Y N
   P. Clicking, popping, pain in jaw joint or ear or Difficulty opening mouth, grinding, clenching teeth Y N
   Q. Sinus or nasal problems Y N
   R. Any disease, drug, or transplant operation that has depressed your immune system Y N
   S. HIV, AIDS Y N
7. Are you taking any:
   A. Antiocoagulants (Blood Thinners) Y N
   B. Steroids (Cortisone, etc) Y N
   C. Aspirin, Motrin, Aleve, Ibuprofen Y N
   D. Osteoporosis meds (Fosamax, Boniva) Y N
   E. List all medications you are taking:
   _____
   _____
   F. List any herbal or holistic remedies, vitamins or over-the counter medications: _____
   _____
8. List any drug allergies: _____
   _____
9. Are you allergic to latex? Y N
10. Do you smoke or chew tobacco? Y N
    How much per day? _____
11. History of alcohol or chemical dependency, Or emotional disorder that may affect the care we provide you? Y N
12. Problems from dental treatment Y N
13. Problems with intravenous anesthesia Y N
14. Any other disease, condition, or problem not listed that you think the doctor should know about? Y N
15. Do you wish to talk to the doctor privately about anything? Y N
16. Does your physician require you to take antibiotics prior to dental procedures? Y N
17. FEMALES ONLY
    A. Are you (or could you be) pregnant? Y N
    B. Are you nursing? Y N
    C. Antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives*

☐ I understand the importance of the truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Signature of Patient, Parent, Guardian completing this form: _____

Relationship to patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other