

# The Cedar Rapids Dental Center

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## MEDICAL HISTORY

**Patient:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Employer Address:** \_\_\_\_\_

**Your current physical health is:**  Good  Fair  Poor **Physician's (Medical Doctor) Name:** \_\_\_\_\_

**Please list any prescription, over-the-counter medicines, herbal or dietary supplements currently being taken and for what conditions:**

\_\_\_\_\_ to treat \_\_\_\_\_ | \_\_\_\_\_ to treat \_\_\_\_\_  
 \_\_\_\_\_ to treat \_\_\_\_\_ | \_\_\_\_\_ to treat \_\_\_\_\_

**Have you ever had or are you currently experiencing any of the following diseases or medical problems? (Please circle Y or N)**

- |  |   |   |
|--|---|---|
| Y N Abnormal Bleeding                        | Y N Glaucoma                                      | Y N Psychiatric Problem                         |
| Y N Alcohol/Drug Abuse                       | Y N Hay Fever                                     | Y N Radiation Treatment                         |
| Y N Alzheimer's Disease                      | Y N Heart Attack                                  | Y N Rheumatic/Scarlet Fever                     |
| Y N Anemia                                   | Y N Heart Disease                                 | Y N Seizures                                    |
| Y N Arthritis                                | Y N Heart Murmur                                  | Y N Shingles                                    |
| Y N Artificial Bones/Joints/Valves           | Y N Heart Surgery                                 | Y N Sickle Cell Anemia                          |
| Y N Asthma                                   | Y N Hemophilia                                    | Y N Sinus Problems                              |
| Y N Blood Transfusion                        | Y N Hepatitis                                     | Y N Special Needs (explain)                     |
| Y N Breast implant/expander<br>(last 12 mos) | Y N Herpes / Fever Blisters                       | _____   |
| Y N Cancer/Chemotherapy                      | Y N High Blood Pressure                           | _____   |
| Y N Cholesterol                              | Y N HIV+/AIDS                                     | Y N Stroke                                      |
| Y N Colitis                                  | Y N Kidney Problems                               | Y N Thyroid Problems                            |
| Y N Congenital Heart Defects                 | Y N Liver Disease                                 | Y N Tuberculosis (TB)                           |
| Y N Diabetes                                 | Y N Low Blood Pressure                            | Y N Ulcers                                      |
| Y N Difficulty Breathing                     | Y N Mitral Valve Prolapse                         | Y N Venereal or Sexually<br>Transmitted Disease |
| Y N Emphysema                                | Y N Pacemaker                                     |   |
| Y N Epilepsy                                 | Y N Periodontal (Gum) Disease<br>(past treatment) | Other _____                                     |
| Y N Fainting Spells                          | Y N Pregnant (currently)<br>Week # _____          |   |
| Y N Frequent Headaches                       |   |   |

**Please list hospitalizations (surgeries, emergency room) within the last year:**

\_\_\_\_\_ to treat \_\_\_\_\_ | \_\_\_\_\_ to treat \_\_\_\_\_  
 \_\_\_\_\_ to treat \_\_\_\_\_ | \_\_\_\_\_ to treat \_\_\_\_\_

**Are you allergic to any of the following? If so, indicate what kind of reaction you had:**

- |                              |                        |
|------------------------------|------------------------|
| Y N Aspirin _____            | Y N Metals _____       |
| Y N Codeine _____            | Y N Latex _____        |
| Y N Dental Anesthetics _____ | Y N Tetracycline _____ |
| Y N Erythromycin _____       | Y N Penicillin _____   |
| Y N Jewelry _____            | Y N Other _____        |

**Do you smoke or use tobacco in any form?**  Yes  No

**Dental Issues.** Please indicate if you wish to discuss treatment of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Areas of pain or sensitivity | <input type="checkbox"/> Straightness of teeth | <input type="checkbox"/> Bleeding of Gums                      |
| <input type="checkbox"/> Bad Breath                   | <input type="checkbox"/> Whiteness of teeth    | <input type="checkbox"/> Alternatives for existing dental work |

**Do you experience anxiety (fear) when receiving dental treatment?**  Yes  No

**Do you need antibiotics before dental treatment?**  Yes (Reason) \_\_\_\_\_  No

Office Use Only	
<b>BP:</b> ____/____	<b>Pulse:</b> _____

\_\_\_\_\_  
 Signature of person completing form

\_\_\_\_\_  
 Relationship if other than patient