Elizabeth V. Wawrzewski,D.D.S.

Medical History Form

Patient Name:____

Are you under a physician's care now? ◯ Yes ◯ No If Yes, Doctor's name: ____

Have you ever been hospitalized or had any operations in the last 10 years? ◯ Yes ◯ No If yes: _________________________________

Have you had a serious head or neck injury? ◯ Yes ◯ No If Yes: ____

Are you taking any medications, pills or drugs? ◯ Yes ◯ No If Yes:

____

Have you ever had to take antibiotics before dental treatment for artificial joints or heart issues? ◯ Yes ◯ No

Do you take, or have taken Phen-Fen or Redux? ◯ Yes ◯ No

Are you presently in treatment or scheduled to begin treatment with intravenous biophosphates (Avedia, Zometa) for bone pain, hypercalcemia or skeletal complications? ◯ Yes ◯ No If yes, date treatment began: ___________________________

Are you on a special diet? ◯ Yes ◯ No If Yes: ____

Do you use tobacco? ◯ Yes ◯ No If yes, how interested are you in stopping? Very / Somewhat / Not Interested

Do you use controlled substances? ◯ Yes ◯ No If Yes: ____

*Women: Are you…… Pregnant / Trying to get pregnant? ◯ Yes ◯ No

Nursing? ◯ Yes ◯ No

Taking oral contraceptives? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin or other antibiotic ◯ Codeine or Narcotics ◯ Acrylic
◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics
◯ Food Allergies ◯ Other

If Yes: __________________________ Please specify reaction type: ____

Do you have, or had any of the following?

- ◯ AIDS / HIV Positive
- ◯ Alzheimer's Disease
- ◯ Anaphylaxis
- ◯ Anemia
- ◯ Angina
- ◯ Arthritis / Gout
- ◯ Artificial Heart Valve
- ◯ Artificial Joint
- ◯ Asthma
- ◯ Blood Disease
- ◯ Blood Transfusion
- ◯ Breathing Problems
- ◯ Bruise Easily
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Chest Pains
- ◯ Cold Sores / Fever Blisters
- ◯ Congenital Heart Disorder
- ◯ Convulsions
- ◯ Yellow Jaundice
- ◯ Cortisone Medicine
- ◯ Diabetes Type 1
- ◯ Diabetes Type 2
- ◯ Easily Winded
- ◯ Emphysema
- ◯ Epilepsy or Seizures
- ◯ Excessive Bleeding
- ◯ Excessive Thirst
- ◯ Fainting Spells / Dizziness
- ◯ Frequent Cough
- ◯ Frequent Diarrhea
- ◯ Frequent Headaches
- ◯ Genital Herpes
- ◯ Glaucoma
- ◯ Hay Fever / Seasonal
- ◯ Heart Attack / Failure
- ◯ Heart Murmur
- ◯ Heart Pacemaker
- ◯ Heart Trouble / Disease
- ◯ Abnormal Bleeding
- ◯ Hemophilia
- ◯ Hepatitis A
- ◯ Hepatitis B or C
- ◯ Herpes
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Hives or Rash
- ◯ Hypoglycemia
- ◯ Irregular Heartbeat
- ◯ Kidney Problems
- ◯ Leukemia
- ◯ Liver Disease
- ◯ Low Blood Pressure
- ◯ Lung Disease
- ◯ Mitral Valve Prolapse
- ◯ Osteoporosis
- ◯ Pain in Jaw Joints
- ◯ Parathyroid Disease
- ◯ Psychiatric Care
- ◯ Sleep Disorder
- ◯ Radiation Treatments
- ◯ Recent Weight Loss
- ◯ Renal Dialysis
- ◯ Rheumatic Fever
- ◯ Rheumatism
- ◯ Scarlet Fever
- ◯ Shingles
- ◯ Sickle Cell Disease
- ◯ Sinus Trouble
- ◯ Spina Bifida
- ◯ Stomach / Intestinal Disease
- ◯ Stroke
- ◯ Swelling of Limbs
- ◯ Thyroid Disease
- ◯ Tonsillitis
- ◯ Tuberculosis
- ◯ Tumors or Growths
- ◯ Ulcers
- ◯ Venereal Disease
- ◯ Mental Health Disorder

Have you had any serious illness not listed above? ____

Although Dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the questions.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X______________________________________ Date: ______________________________