G J Smiles

Carl A. Feghali DDS, PC

MEDICAL HISTORY

Patient Name	Birth Date

- When was your last dental visit? ____________ Chief dental concern? ____________
- Do you like the way your smile looks? ☐ Yes ☐ No What would you change? ____________
- Are you under a physician's care now? ☐ Yes ☐ No If yes, for what reason? ____________
- Physician's name ____________ Phone number ____________
- Have you been hospitalized in the last 5 years? ☐ Yes ☐ No Reason? ____________
- Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain ____________
- Are you taking any medications, pills or drugs including supplements? ☐ Yes ☐ No

  If yes, what are you taking? ____________
- Do you snore? ____________ Do you have Sleep Apnea? ____________ Do you use a CPAP? ____________
- Are you on a special diet? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Do you use controlled substances including cocaine? ☐ Yes ☐ No If yes, what are you taking? ____________
- Do you use alcohol on a regular basis? ☐ Yes ☐ No If yes, how often? ____________
- Are you pregnant/trying to get pregnant? ☐ Yes ☐ No
- Nursing? ☐ Yes ☐ No
- Taking oral contraceptives? ☐ Yes ☐ No

WARNING - Antibiotics can make birth control pills less effective.

- Are you allergic to any of the following?

☐ Aspirin / Ibuprophen / Tylenol ☐ Penicillin / Antibiotics ☐ Codeine / Valium / Sedatives ☐ Sulfa ☐ Iodine

☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics ☐ Other ____________

- Do you have, or have you had, any of the following?

☐ AIDS / HIV Positive*/ ARC
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis / Gout / Rheumatism
☐ Artificial Heart Valve*/ Stent
☐ Artificial Joint*
☐ Asthma
☐ Abnormal Bleeding
☐ Blood Disorders / Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores / Fever Blisters
☐ COPD (Bronchitis / Emphysema)
☐ Congenital Heart Disorder
☐ Convulsions
☐ Coronary Artery Disease
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Dry Mouth
☐ Easily Winded
☐ Epilepsy or Seizures
☐ Excessive Thirst
☐ Fainting Spells / Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Gastrointestinal Disease
☐ Genital Herpes
☐ G.E. Reflux / Persistent Heartburn
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack / Disease
☐ Heart Murmur*
☐ Hemophilia
☐ Hepatitis any forms
☐ Herpes
☐ High Blood Pressure
☐ History of Bulimia or Anorexia
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease / Jaundice
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse*
☐ Pacemaker
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments / Chemo
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Respiratory Problems
☐ Rheumatic Fever*
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Sores or Ulcers
☐ Spina Bifida
☐ Stomach / Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Systematic Lupus
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease

**** May require pre-medication***

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• Are you taking any of these medications?

Pre-medication before dental treatment?	☐ No	☐ Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	☐ No	☐ Yes
Antacids?	☐ No	☐ Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	☐ No	☐ Yes
Dilantin® or Tegretol®	☐ No	☐ Yes	Serzone® (nefazodone)	☐ No	☐ Yes
Barbiturates (any)	☐ No	☐ Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	☐ No	☐ Yes
St. John's Wort or Kava-Kava?	☐ No	☐ Yes	Biaxin® (clarithromycin)	☐ No	☐ Yes

Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? ☐ No ☐ Yes

If so, when did the treatment begin? When did the treatment end?

Have you ever taken any prescription drugs such as fen-phen for weight loss? ☐ No ☐ Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract? ☐ No ☐ Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be hazardous 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   Date

MEDICAL HISTORY UPDATE

1 • Date ---------------- Changes: ----------------

2 • Date ---------------- Changes: ----------------

3 • Date ---------------- Changes: ----------------

4 • Date ---------------- Changes: ----------------

5 • Date ---------------- Changes: ----------------

6 • Date ---------------- Changes: ----------------