Medical History

University of the Pacific, Arthur A. Dugoni School of Dentistry

Patient Name________________________________ Birth Date_____________ ID Number____________

1. **Do you have any of the following diseases or problems?** Today's Date____________
   a. Active Tuberculosis
   b. Persistent cough greater than 3 weeks in duration
   c. Cough that produces blood
   d. Been exposed to anyone with Tuberculosis
   e. Describe positive and/or unanswered questions__________________________

2. **What is your impression of your health?**
   a. Date of last physical exam ___________________

3. **Are you now, or have you been in the past year, under the care of a physician?**

4. **Have you had any serious illness, operation, or been hospitalized in the past 5 years?**

5. **Have you had an organ transplant?**

6. **Do you have a history of Endocarditis (infected heart valve)?**

7. **Have you had open heart surgery?**
   a. If yes, when was your heart surgery (year)?__________
   b. Was an artificial heart valve implanted?

8. **Have you had an orthopedic total joint (e.g. hip, knee, elbow, finger) replacement?**

9. **Have you ever had any radiation therapy or chemotherapy for a growth, tumor or other condition?**

10. **In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)?**

11. **Do you use or have you used tobacco (smoking, snuff, chew, bidis)?**
    a. If yes, please specify amount per day:
    b. For how many years
    c. If yes, how interested are you in stopping

12. **Do you drink alcoholic beverages?**
    a. If yes, how many drinks did you drink in the last 24 hours?
    b. If yes, how many drinks do you typically drink in a week?
    c. If yes, are you alcohol dependent?
    d. If yes, how long have you been alcohol dependent (months)?
    e. If yes, have you received treatment?

13. **Do you use prescription or street drugs or other substances for recreational purposes?**
    a. If yes, how often do you use?
    b. If yes, are you drug dependent?
    c. If yes, how long have you been drug dependent (months)?
    d. If yes, have you received treatment?

14. **Have you taken, are you taking or are you scheduled to begin taking?**
    a. Oral bisphosphonates (Alendronate (Fosamex, Fosamex Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid))?
    b. If yes, what drug, dose and frequency?
    c. If yes, what for?
    d. If yes, when?

15. **Have you taken, are you taking or are you scheduled to begin taking?**
    a. Intravenous bisphosphonates (Clodronate (Bonefos), Pamidronate (Aredia) or Zolodronic Acid (Reclast, Zometal))?
    b. If yes, what drug, dose and frequency?
    c. If yes, what for?
    d. If yes, when?

16. **Women only:**
    a. Are you pregnant?
    b. Are you trying to become pregnant?
    c. Are you nursing?
    d. Are you taking birth control pills, fertility drugs or hormonal replacement?

ALLERGIES:

Are you allergic to or have you had a reaction to any of the following?
For yes responses, please specify type of reaction:

17. Local anesthetics (or their preservatives)
18. Penicillin
19. Sulfa drugs
20. Other antibiotics
21. Codeine or other narcotics
22. Aspirin
23. Barbiturates (sedatives or sleeping pills)
24. Hay fever/seasonal (allergic rhinitis)
25. Animals
26. Metals/Jewelry (nickel/chrome)
27. Food
28. Iodine
29. Latex (rubber)
30. Other/Other Medication(s)

MEDICAL CONDITIONS:

Do you have or have you had any of the following diseases, problems, or symptoms?

If yes, please specify:

31. ***Cardiovascular/Heart problem***
    a. Rheumatic fever/ rheumatic heart disease
    b. Infective endocarditis
    c. Artificial heart valves
    d. Congenital heart defect
    e. Heart murmur
    f. Mitral valve prolapsed
    g. Angina (chest pain)
    h. Heart attack
    i. Heart failure
    j. Coronary heart disease
    k. High blood pressure
    l. Low blood pressure
    m. Arteriosclerosis
    n. Palpitations
    o. Arrhythmia (irregular heart beat)
    p. Shortness of breath
    q. Swelling of the ankles
    r. Pacemaker
    s. Implantable defibrillator
    t. Sleep on two or more pillows
32. ***Respiratory/Lung problem***
    a. Asthma
    b. Emphysema/COPD
    c. Tuberculosis
    d. Sarcoidosis
    e. Pneumonia
    f. Sinusitis
    g. Bronchitis
    h. Persistent cough
    i. Sleep apnea
    j. Snoring
33. ***Diabetes/Endocrine disorder***
    a. Diabetes
    b. Thyroid problems
    c. Adrenal gland disorder
34. ***Kidney/Urogenital disorder***
    a. Kidney stones
    b. Renal failure/insufficiency
    c. Dialysis
    d. Prostate
    e. Frequent urination
35. ***Cancer or Tumors***
    a. Malignant
    b. Benign

36. ***Neurologic/Nerve problem***

a. Stroke
b. TIA (transient ischemic attack)
c. Seizures/epilepsy
d. Multiple sclerosis
e. Parkinson's disease
f. Neuropathies
g. Dementia/Alzheimer's (memory loss)
h. Headache
i. Fainting or dizzy spells
j. Weakness
k. Feeling of tingling or numbness
l. Mental health disorder
m. Post traumatic stress disorder
n. Obsessive/compulsive disorder
o. ADD/ADHD (attention deficit disorder)
p. Feelings of anxiety
q. Feelings of depression

37. ***Blood/Hematologic disorder***

a. Anemia
b. Thalassemia
c. Sickle cell disease/trait
d. Deep vein thrombosis
e. Bruise easily
f. Leukemia
g. Lymphoma
h. Multiple myeloma
i. Bleeding disorders

38. ***Gastrointestinal (GI) disorder***

a. Cirrhosis/chronic hepatitis
b. Jaundice (skin/eyes turn yellow)
c. Hepatitis
d. Heart burn
e. Acid reflux (GERD)
f. Gall stones
g. Ulcers
h. Crohn's disease
i. Irritable bowel syndrome

39. ***Musculoskeletal/Connective tissue disorder***

a. Arthritis
b. Osteoporosis
c. Gout
d. Temporomandibular joint disorder
e. Lupus
f. Sclerodema
g. Fibromyalgia
h. Joint replacement

40. ***Infectious disease***

a. HIV
b. AIDS
c. Methicillin-resistant Staph aureus (MRSA)
d. STD (sexually transmitted disease)
e. Cold sores
f. Mononucleosis

41. ***Head/Eye/Ear/Nose/Throat problem***
    a. Vision problems
    b. Wear contact lenses
    c. Glaucoma
    d. Cataract
    e. Hearing impairment
42. ***Dermatologic/Skin problem***
    a. Psoriasis(dry skin)
    b. Other______________________
43. ***Eating disorder***
    a. Bulimia
    b. Anorexia
44. **Immunosuppression**

45. **Family history of diabetes: If yes, who?**

46. **Family history of heart disease: If yes, who?**

47. **Family history of cancer/tumors: If yes, who?**

48. **Do you have any other problem, disease or condition not listed above?**