J. Benjamin Patrick
D.M.D., F.A.G.D., P.C.

PERSONAL AND MEDICAL HISTORY

Name _____ Age ____ Sex____ Birthdate _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss. ❑ Dr. ❑ Rev. ❑ Other_____

Home Address _____ City/State/Zip _____

Home Phone _____ Cell Phone: _____ Social Security #_____

❑ Married ❑ Single ❑ Divorced ❑ Widow ❑ Widower

Employed By _____ Position _____ How Long? _____

Bus. Address _____ City/State/Zip_____ Bus. Phone_____

Who may we thank for sending you to our office?_____

What prompted you to make this appointment? _____

Spouse's Name _____

Spouse's S.S.# _____

Employed By _____ Position _____ How Long? _____

Bus. Address _____ City/State/Zip_____ Bus. Phone_____

If you are a college student or a minor,

Parent's Name _____Home Phone_____

Parent's Address _____ City/State/Zip _____

Father Employed By _____ Mother Employed By _____

Address _____ Address _____

Bus. Phone _____ Bus. Phone _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records and will be considered confidential.

1. Are you in good health? ..... Yes No

2. Has there been any change in your general health within the past year? ..... Yes No

3. When was your last physical exam? _____

4. Are you now under the care of a physician? ..... Yes No

   a. If so, what condition? _____

5. What is the name and address of your physician? _____

_____

_____

6. Have you ever had any serious illness or operation? ..... Yes No

   a. If so, what was it?_____

7. Have you been hospitalized within the last 5 years? ..... Yes No

   a. If so, why? _____

8. Do you have or have you had any of the following diseases or problems? If YES, place (√) in box; if NO, leave box blank.

- ❑ Mitral Valve Prolapse (MVP)
- ❑ Artificial Heart Valves
- ❑ Damaged Heart Valves
- ❑ Congenital Heart Disease
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Heart Insufficiency
- ❑ Coronary Occlusion
- ❑ Arteriosclerosis
- ❑ Heart Trouble / Heart Surgery
- ❑ Heart Attack
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Pains in Chest
- ❑ Shortness of Breath
- ❑ Cardiac Pacemaker
- ❑ Ankle Swelling
- ❑ Ulcers (Stomach, Intestinal)
- ❑ Thyroid Problems
- ❑ Kidney Trouble
- ❑ Tuberculosis
- ❑ Persistent Cough
- ❑ Cough up blood
- ❑ Emphysema
- ❑ Asthma
- ❑ Low Blood Pressure
- ❑ Persistent Swollen Glands
- ❑ Epilepsy
- ❑ Other Neurological Disease
- ❑ Cancer - Type? _____
- ❑ Chemotherapy
- ❑ Radiation Therapy
- ❑ Immune System Problems
- ❑ Fever Blisters
- ❑ Nervousness / Anxiety
- ❑ Psychological Treatment
- ❑ Psychiatric Treatment
- ❑ Problem with Mental Health
- ❑ Hives or Skin Rash
- ❑ Sinus Trouble
- ❑ Allergy (dust, pollen, etc.)
- ❑ Fainting Spells or Seizures
- ❑ Diabetes
- ❑ Urinate Very Often
- ❑ Thirsty Much of Time
- ❑ Mouth Frequently Dry
- ❑ Glaucoma
- ❑ Hepatitis - Type? _____
- ❑ Liver Disease
- ❑ Arthritis
- ❑ Inflammatory Rheumatism
- ❑ Sexually Transmitted Disease
- ❑ AIDS
- ❑ HIV Positive
- ❑ Cortisone Therapy
- ❑ Cosmetic Surgery
- ❑ Hemophilia
- ❑ Abnormal Bleeding
- ❑ Bruise Easily
- ❑ Blood Transfusion
- ❑ Anemia
- ❑ Sickle Cell Disease
- ❑ Tumor or Growth
- ❑ Artificial Joint (Hip, Knee, etc.)
- ❑ Alcoholism
- ❑ Drug Dependency or Addiction
- ❑ Eating Disorder
- ❑ Other? _____
- ❑ Other? _____

9. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes No

If yes, did you take any of the following?

Yes	No	Fen-Phen (Fenfluramine-Phenpermine)
Yes	No	Pondimen (fenfluramine)
Yes	No	Redux (dexfenfluramine)

If yes to any of the above, did you have a medical exam for heart issues? ..... Yes No

Have you ever been told to **Premedicate** before a dental procedure? ..... Yes No

If yes, please explain:_____

_____

10. Are you ALLERGIC to or have you had an adverse reaction to any of the following? If YES, place a (√) in box; if NO, leave box blank

- ❑ Local Anesthetics
- ❑ Novocaine or Xylocaine
- ❑ Penicillin
- ❑ Tetracyclines (mino-, doxy-)
- ❑ Other Antibiotics
  What? _____
- ❑ Sulfa Drugs
- ❑ Barbiturates
- ❑ Sedatives
- ❑ Aspirin
- ❑ Latex
- ❑ Iodine
- ❑ Codeine or Other Narcotics
- ❑ Other? _____

11. Are you TAKING any of the following? If YES, place (√) in box; if NO, leave box blank.

- ❑ Antibiotics or Sulfa Drugs
- ❑ Anticoagulants (Blood Thinners)
- ❑ Medication for High Blood Pressure
- ❑ Medication for Heart Condition
- ❑ Nitroglycerin
- ❑ Tranquilizers
- ❑ Hormone Therapy
- ❑ Antihistamines
- ❑ Aspirin
- ❑ Medication for Diabetes
- ❑ Cortisone (Steroids)
- ❑ Iodine
- ❑ Oral Contraceptives
- ❑ Over the Counter Medications _____

Please list name and dosages of all medications you take: _____

_____

_____

12. Do you use any type of tobacco products? ..... Yes No

If so, explain _____

13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No

If so, explain _____

14. Do you have any disease, condition, or problem not listed above? ..... Yes No

If so, explain _____

15. Are you employed in any situation which exposes you to radiation? ..... Yes No

16. Are you wearing contact lenses? ..... Yes No

17. Have you carefully read all of the above and marked ALL those that apply? ..... Yes No

WOMEN

18. Are you pregnant? ..... Yes No

If so, what month? _____

19. Do you have any problems with your menstrual cycle?..... Yes No

20. Are you nursing? ..... Yes No

21. Do you take *or* have you ever taken any of the following medications:
Please list date you started *and/or* stopped the medication.

Actonel (risedronate sodium)
Dosage and frequency: _____ Start Date: _____ Stop Date:_____

Fosamax (alendronate)
Dosage and frequency: _____ Start Date: _____ Stop Date:_____

Boniva (ibandronate)
Dosage and frequency: _____ Start Date: _____ Stop Date:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

_____ _____

Signature of Patient, Parent/Guardian Date Signature of Dentist/Hygienist Date