DR. STEPHANIE MISCO SHELESTAK DMD, PC

# Medical history

Name: _____ Birthdate: _____

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 following questions.

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | Are you under a physician's care now? | If yes, please explain: _____ |
| ☐ | ☐ | Have you ever been hospitalized or had a major operation? | If yes, please explain: _____ |
| ☐ | ☐ | Have you ever had a serious neck or head injury? | If yes, please explain: _____ |
| ☐ | ☐ | Are you taking any medications, pills, or drugs? | If yes, please explain: _____ |
| ☐ | ☐ | Do you take, or have you taken, Phen-Fen or Redux? | |
| ☐ | ☐ | Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing Bisphosphonates? | |
| ☐ | ☐ | Are you on a special diet? | |
| ☐ | ☐ | Do you use tobacco? | |
| ☐ | ☐ | Do you use controlled substances? | If yes, please explain: _____ |
| ☐ | ☐ | Do you need to pre-medicate prior to dental procedures? | |

Women, are you: (Please checkmark which applies to you)

☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Are you allergic to any of the following? (Please checkmark which applies to you)

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex

☐ Other: If yes, please explain: _____

_____

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

| YES | NO | | YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | AIDS/HIV Positive | ☐ | ☐ | Cortisone Medicine | ☐ | ☐ | Hemophilia | ☐ | ☐ | Recent Weight Loss |
| ☐ | ☐ | Alzheimer's Disease | ☐ | ☐ | Diabetes | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Renal Dialysis |
| ☐ | ☐ | Anaphylaxis | ☐ | ☐ | Drug Addiction | ☐ | ☐ | Hepatitis B or C | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Anemia | ☐ | ☐ | Easily Winded | ☐ | ☐ | Herpes | ☐ | ☐ | Rheumatism |
| ☐ | ☐ | Angina | ☐ | ☐ | Emphysema | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Scarlet Fever |
| ☐ | ☐ | Arthritis/Gout | ☐ | ☐ | Epilepsy or Seizures | ☐ | ☐ | High Cholesterol | ☐ | ☐ | Shingles |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Hives or Rash | ☐ | ☐ | Sickle Cell Disease |
| ☐ | ☐ | Artificial Joint | ☐ | ☐ | Excessive Thirst | ☐ | ☐ | Hypoglycemia | ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | Asthma | ☐ | ☐ | Fainting Spells / Dizziness | ☐ | ☐ | Irregular Heartbeat | ☐ | ☐ | Spina Bifida |
| ☐ | ☐ | Blood Disease | ☐ | ☐ | Frequent Cough | ☐ | ☐ | Kidney Problems | ☐ | ☐ | Stomach/Intestinal Disease |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Frequent Diarrhea | ☐ | ☐ | Leukemia | ☐ | ☐ | Stroke |
| ☐ | ☐ | Breathing Problem | ☐ | ☐ | Frequent Headaches | ☐ | ☐ | Liver Disease | ☐ | ☐ | Swelling of Limbs |
| ☐ | ☐ | Bruise Easily | ☐ | ☐ | Genital Herpes | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Thyroid Disease |
| ☐ | ☐ | Cancer | ☐ | ☐ | Glaucoma | ☐ | ☐ | Lung Disease | ☐ | ☐ | Tonsillitis |
| ☐ | ☐ | Chemotherapy | ☐ | ☐ | Hay Fever | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Chest Pains | ☐ | ☐ | Heart Attack / Failure | ☐ | ☐ | Pain in Jaw Joints | ☐ | ☐ | Tumors or Growths |
| ☐ | ☐ | Cold Sores / Fever Blisters | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Parathyroid Disease | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Congenital Heart Disorder | ☐ | ☐ | Heart Pacemaker | ☐ | ☐ | Psychiatric Care | ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Convulsions | ☐ | ☐ | Heart Trouble / Disease | ☐ | ☐ | Radiation Treatments | ☐ | ☐ | Yellow Jaundice |

Have you ever had any serious illness not listed above? If yes, please explain: _____

_____

Comments: _____

_____

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 _____ DATE _____