DR T DENTAL
COSMETIC & GENERAL DENTISTRY
ATTILA FRANK TALABER, D.M.D.
AFFILIATE PROFESSOR U. OF W.

MEDICAL HISTORY FORM

DATE:_____NAME:_____BIRTH DATE:_____

FOR THE FOLLOWING QUESTIONS CIRCLE YES OR NO, YOUR ANSWERS ARE CONFIDENTIAL.

WHO IS YOUR PRIMARY MEDICAL PHYSICIAN?_____

WHEN WAS YOUR LAST PHYSICAL EXAM?_____

IN THE PAST 5 YEARS HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION, OR BEEN HOSPITALIZED?
DESCRIBE_____

LIST ALL PRESCRIPTION DRUGS, NON-PRESCRIPTION DRUGS OR VITAMINS YOU CURRENTLY TAKE_____

ARE YOU ALLERGIC TO:

ASPIRIN	YES/NO	METALS OF ANY KIND	YES/NO
IODINE	YES/NO	LATEX PRODUCTS	YES/NO
CODIENE OR NARCOTICS	YES/NO	LOCAL ANESTHETICS	YES/NO
PENICILLIN OR OTHER ANTIBIOTICS	YES/NO		

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

HEART DISEASE, ARTIFICIAL VALVES OR RHEUMATIC FEVER YES/NO

DO YOU REQUIRE PRE-MEDICATION ? YES/NO

CARDIOVASCULAR : HEART ATTACK, ANGINA, HIGH BLOOD PRESSURE, STROKE, ARTERIOSCLEROSIS YES/NO

CHEST PAIN UPON EXERTION	YES/NO	PSYCHIATRIC PROBLEMS	YES/NO
CARDIAC PACEMAKER	YES/NO	ANKLES THAT SWELL	YES/NO
INBORN HEART DEFECTS	YES/NO	RESPIRATORY PROBLEMS	YES/NO
SINUS TROUBLE	YES/NO	PERSISTENT COUGH	YES/NO
ASTHMA/HAY FEVER	YES/NO	EPILEPSY OR NEUROLOGICAL ISSUES	YES/NO
TUBERCULOSIS	YES/NO	CANCER, GROWTH OR TUMOR	YES/NO
FAINTING OR SEIZURES	YES/NO	DIARRHEA OR WEIGHT LOSS	YES/NO
LOW BLOOD PRESSURE	YES/NO	SWOLLEN GLANDS IN NECK	YES/NO
BLOOD TRANSFUSION	YES/NO	HEPATITIS, JAUNDICE OR LIVER DISEASE	YES/NO
DRUG ADDICTION	YES/NO	SEXUALLY TRANSMITTED DISEASE	YES/NO
AIDS OR HIV	YES/NO	IMMUNE SYSTEM PROBLEMS	YES/NO

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BRUSE EASILY OR SLOW HEALING	YES/NO	ANEMIA OR BLOOD DISORDERS	YES/NO
DIABETES	YES/NO	STOMACH ULCER OR HYPERACIDITY	YES/NO
THYROID PROBLEMS	YES/NO	COLD SORES (HERPES)	YES/NO
KIDNEY PROBLEMS	YES/NO	ARTIFICIAL JOINTS OR PROSTHESIS	YES/NO
PREGNANT	YES/NO	BURSITIS OR ARTHRITIS	YES/NO
BACK PROBLEMS	YES/NO	INSOMNIA OR SLEEP DISORDERS	YES/NO
CHEMOTHERAPY	YES/NO	DO YOU USE TOBACCO	YES/NO

WHY ARE YOU SEEKING DENTAL TREATMENT?_____

BLEEDING GUMS	YES/NO	PERIODONTAL (GUM) DISEASE	YES/NO
INJURY TOFACE OR JAW	YES/NO	DIFFICULTY OPENING MOUTH	YES/NO
JAW PROBLEMS	YES/NO	TEETH SENSITIVITY	YES/NO
DRY MOUTH	YES/NO	PAIN IN OR NEAR EARS, TEMPLES	YES/NO
PAIN WITH CHEWING	YES/NO	CLENCHING OR GRINDING	YES/NO
HEADACHES	YES/NO	BLISTERS OR SORES IN/OUT OF MOUTH	YES/NO

SLEEP APNEA, SNORING OR USE A C-PAP YES/NO

LAST DENTAL VISIT_____LAST DENTAL CLEANING_____WHERE?_____

DO YOU HAVE RECORDS OR X-RAYS AT ANOTHER PLACE WE CAN GET FOR YOU?_____

DO YOU HAVE DENTAL ANXIETY?_____EXPLAIN_____

WOULD YOU CHANGE ANYTHING ABOUT YOUR TEETH?_____

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICATIONS CHANGE, I WILL INFORM MY DENTIST AT MY NEXT APPOINTMENT.

X_____DATE_____

SIGNATURE OF PATIENT OR PARENT (GUARDIAN) OF MINOR

X_____

PRINT NAME