

Catalina Dental Medical/Dental History

Please Complete the Following Confidential Medical/Dental History Information

Patient Name: _____ **Date:** _____
 Primary Care Physician: _____ Dr. Phone #: _____
 Medical Specialist: _____ Dr. Phone #: _____
 Are you under ongoing Medical Care now? **YES NO** For What Condition? _____
 Any Surgery/Hospital visit in the last 3 years? **YES NO** Please explain Procedures/Conditions: _____

Do you take an **antibiotic pre-medication** prior to dental visits? **YES NO** Name of Medication: _____

Please List ALL **Medications/Supplements** you currently take: _____

Have you ever taken Bone Density Drugs? (Fosamax, Boniva, etc) **YES NO** Drug Name/How Long? _____
 Please **circle** any medications/materials you are **Allergic** to? Anesthetics Latex Penicillin Sulfa Aspirin Metals Codeine

List any ALL other **Allergies**: _____

Do you use tobacco and/or controlled substances? If yes, list type and frequency: _____

Please circle YES or NO for each item that you have now or have had before:

YES NO Abnormal Bleeding YES NO AIDS/HIV Positive YES NO Alzheimer's YES NO Anemia YES NO Angina YES NO Arthritis/Gout YES NO Artificial Joint / Bone YES NO Asthma YES NO Blood Disease YES NO Bruise Easily YES NO COPD YES NO Cancer _____ YES NO Chemo / Radiation YES NO Chest Pains YES NO Cold Sores YES NO Colitits YES NO Diabetes	YES NO Emphysema YES NO Epilepsy / Seizures YES NO Fainting / Dizziness YES NO Glaucoma YES NO Heart Attack / Failure YES NO Heart Disease YES NO Heart Murmur YES NO Heart Pacemaker YES NO Heart Surgery YES NO Heart Valves (Artificial) YES NO Hemophilia YES NO Hepatitis Type____ YES NO High Blood Pressure YES NO High Cholesterol YES NO Hypoglycemia YES NO Jaundice YES NO Kidney Problems	YES NO Liver Disease YES NO Low Blood Pressure YES NO Lung Disease YES NO Mitral Valve Prolapse YES NO Osteoporosis YES NO Psychiatric Care YES NO Rheumatic Fever YES NO Shingles YES NO Sickle Cell Disease YES NO Sinus Problems YES NO Stomach Disease YES NO Stroke YES NO Substance Abuse YES NO Swelling of Limbs YES NO Thyroid Problems YES NO Tuberculosis YES NO Ulcers	YES NO Neck/Jaw Injury YES NO Clench / Grind Teeth YES NO Jaw Click / Pop YES NO Bleeding Gums YES NO Frequent Headaches YES NO Orthodontic Treatment WOMEN ONLY, Are you currently: YES NO Pregnant YES NO Nursing YES NO Taking Bith Control Any Condition Not Listed: _____ _____ _____
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Do you wear dentures or partials? **YES NO** Upper - How Long? _____ Lower - How Long? _____
 Have you had regular dental care? **YES NO** Date of Last Visit to Dentist? _____
 Do you have dental pain / problems today? **YES NO** Please Describe: _____

Please inform us of any special needs during dental treatment: _____

I certify that I have responded to the above information and to the best of my ability. I understand that providing incorrect information can be dangerous to my health. I will notify this office of any changes in my health or medications.

Signature of Patient (If patient is a minor, Signature of Guardian) **Date**