Patient Medical History

Mark P. Tompkins, DDS,
FAGD, LVIF, FIAPA, DABDSM
19109 West Catawba Avenue • Suite 108
Cornelius, NC 28031
704-895-3833

Patient Name ______________________ Date ____________

Height ____________ Weight ____________ Age ____________ Date of Birth ____________

Name of your Physician ______________________ Office Phone ____________

Address of your Physician ______________________

1. Are you in good health? ❒ Yes ❒ No ❒ Don't Know
2. Has there been any change in your health in the last year? ❒ Yes ❒ No ❒ Don't Know

   If yes, explain: ______________________
3. Have you ever been hospitalized, had a major operation or serious illness? ❒ Yes ❒ No ❒ Don't Know

   If yes, explain: ______________________
4. Date of your last visit to your doctor? ____________ Reason for last visit? ____________

   ____
5. Are you currently receiving treatment or regular medical care by your doctor? ❒ Yes ❒ No ❒ Don't Know

   If yes, for what condition(s)?
6. Are you taking any of the following medications?
   - a. Antibiotics or sulfa drugs ❒ Yes ❒ No ❒ Don't Know
   - b. Anticoagulant (blood thinners) ❒ Yes ❒ No ❒ Don't Know
   - c. Medicine for high blood pressure ❒ Yes ❒ No ❒ Don't Know
   - d. Cortisone (steroids) ❒ Yes ❒ No ❒ Don't Know
   - e. Tranquilizers ❒ Yes ❒ No ❒ Don't Know
   - f. Antihistamines ❒ Yes ❒ No ❒ Don't Know
   - g. Aspirin ❒ Yes ❒ No ❒ Don't Know
   - h. Insulin, tolbutamide (Orinase) or other drugs for diabetes ❒ Yes ❒ No ❒ Don't Know
   - i. Digitalis or drugs for heart trouble ❒ Yes ❒ No ❒ Don't Know
   - j. Nitroglycerin ❒ Yes ❒ No ❒ Don't Know
   - k. Birth control pills or other hormones ❒ Yes ❒ No ❒ Don't Know
   - l. Pain medications such as Advil, Nuprin, Motrin or Naprosyn ❒ Yes ❒ No ❒ Don't Know
   - m. Synthyroid or other thyroid medication ❒ Yes ❒ No ❒ Don't Know
   - n. Phen/Fen ❒ Yes ❒ No ❒ Don't Know
   - o. Others, please list: ______________________
7. Are you allergic to or have you had any unusual reactions to:
   - a. ANTIBIOTICS (List) ❒ Yes ❒ No
   - b. CODEINE ❒ Yes ❒ No ❒ Don't Know
   - c. OTHER DRUGS OR MEDICINES (List) ______________________ ❒ Yes ❒ No

HAVE YOU EVER HAD OR BEEN TREATED BY A DOCTOR FOR: *(Check your response and underline any condition(s) that apply)*

8. Damaged heart valves or artificial heart valves, including heart murmur, mitral valve prolapse, rheumatic fever, rheumatic heart disease, or artificial joints or valves ❒ Yes ❒ No ❒ Don't Know
9. Congenital heart problems ❒ Yes ❒ No ❒ Don't Know
10. Heart trouble, heart attack, high blood pressure, stroke ❒ Yes ❒ No ❒ Don't Know
    - a. Do you have pain in your chest upon exertion? ❒ Yes ❒ No ❒ Don't Know
    - b. Are you ever short of breath after mild exercise? ❒ Yes ❒ No ❒ Don't Know
    - c. Do your ankles swell? ❒ Yes ❒ No ❒ Don't Know

11. Severe or frequent headaches? Sinus problems? ❒ Yes ❒ No ❒ Don't Know
12. Blood disorders such as anemia or hemophilia? ❒ Yes ❒ No ❒ Don't Know
13. Breathing problems, emphysema, tuberculosis, or other lung problems? ❒ Yes ❒ No ❒ Don't Know
14. Asthma, hay fever, or hives? ❒ Yes ❒ No ❒ Don't Know
15. Stomach or intestinal disease, or ulcers? ❒ Yes ❒ No ❒ Don't Know
16. Cancer, x-ray treatments, or chemotherapy? ❒ Yes ❒ No ❒ Don't Know
17. Diabetes or blood sugar problems? ❒ Yes ❒ No ❒ Don't Know
18. Hepatitis, jaundice, or liver disease? ❒ Yes ❒ No ❒ Don't Know
19. Kidney infections, frequent urination, or renal (kidney) dialysis? ❒ Yes ❒ No ❒ Don't Know
20. Stroke, seizures, fainting spells, numbness, or other neurological problems? ❒ Yes ❒ No ❒ Don't Know
21. Syphilis, gonorrhea, or genital herpes? ❒ Yes ❒ No ❒ Don't Know
22. AIDS, AIDS-related condition, or HIV positive? ❒ Yes ❒ No ❒ Don't Know
23. Tumors or growths? ❒ Yes ❒ No ❒ Don't Know
24. Arthritis or rheumatism? ❒ Yes ❒ No ❒ Don't Know
25. Phobias, severe anxieties, depression, psychoses, unusual fears, or other mental problems? ❒ Yes ❒ No ❒ Don't Know
26. Psoriasis, seborrhea, or other skin diseases? ❒ Yes ❒ No ❒ Don't Know
27. Have you lost weight without dieting or gained weight in recent months? ❒ Yes ❒ No ❒ Don't Know
28. Do you have complaints regarding your eyes, ears, or nose? ❒ Yes ❒ No ❒ Don't Know

    If yes, explain: ______________________________
29. Do you wear contact lenses? ❒ Yes ❒ No ❒ Don't Know
30. Do you now use or have you ever used recreational drugs? ❒ Yes ❒ No ❒ Don't Know
31. How many packs of cigarettes do you smoke per day? ________ packs per day
32. How many drinks of beer, wine, or liquor do you drink per day? ________ drinks per day
33. For women, are you pregnant or do you think you may be pregnant? ❒ Yes ❒ No ❒ Don't Know
34. Are there any other problems about your health that you know of? ❒ Yes ❒ No ❒ Don't Know

    If yes, describe: ______________________________

SIGNATURE OF PATIENT: *I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.*

PERSON COMPLETING THIS FORM: Signature ______________________________ Date ____________

If other than patient, indicate relationship: ______________________________

DO NOT WRITE BELOW THIS LINE

SUMMARY OF HISTORY AND NOTATION OF SIGNIFICANT FINDINGS BY DOCTOR