MEDICAL HISTORY

Kurt C. Rolf, DDS

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.

Are you under a physician's care now? ***YES NO I DON'T KNOW***
Date of last physical examination? ______________________________
Have you ever been hospitalized or had a major operation? ***YES NO I DON'T KNOW***
Have you ever had serious head or neck injury? ***YES NO I DON'T KNOW***
Are you taking any medicine(s) including non-prescription medicine? ***YES NO I DON'T KNOW***

If yes, what medicine(s) are you taking? Please list below.
Prescribed:
____
____

Over the Counter:
____
____

Vitamins, natural or herbal preparations and/or diet supplements:
____
____

Do you take, or have you taken, any diet drugs such as Phen-Fen, Pondimin, or Redux? ***YES NO***
Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates? ***YES NO***
Do you snore? ***YES NO***
Do you have hypertension/ high blood pressure? ***YES NO***
Has anyone witnessed a sleep apnea/choking episode? ***YES NO***
Is your neck size for male >17" female >15"? ***YES NO***
Have you ever been told you have sleep apnea or do use a CPAP machine? ***YES NO***
Do you use tobacco? ***YES NO***

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO?
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs
Other, if yes, please explain: ______________________________

Have you had an Orthopedic Total Joint (Hip, Knee, Elbow, Finger) Replacement? **YES NO**
PleaseExplain:______________________________
Have you ever been told to **PREMEDICATE** with antibiotics prior to a dental appointment? **YES NO**

WOMEN ONLY:
Pregnant/Trying to get Pregnant? ***YES NO*** ______________________________
Taking Oral Contraceptives? ***YES NO*** ______________________________
Nursing? ***YES NO*** ______________________________

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Kurt C. Rolf, DDS

Do you have or have you ever had any of the following? Please indicate.

	AIDS/HIV Positive		Emphysema/Bronchitis		Mitral Valave Proplapse
	Alzheimer/Dementia		Epilepsy or Seizures		Neurological Disorders
	Anaphylaxis		Excessive Bleeding		Night Sweats
	Anemia		Excessive Thrist		Osteoporsis
	Angina		Fainting Spells/Dizziness		Pain in Jaw Joint
	Abnormal bleeding		Frequent Cough		Parathyroid Disease
	Arthritis/Gout		Glaucoma		Psychiatric Care
	Artificial Heart Valve		Headaches/Migraines		Radiation Treatment
	Artificial Joint		Hay Fever		Recent Weight Loss
	Asthma		Heart Attack/Failure		Rheumatic Fever
	Blood transfusion		Heart Murmur		Rheumatism
	Breathing Problem		Heart Pacemaker		Scarlet Fever
	Bruise Easily		Heart Trouble/Disease		Sickle Cell Disease
	Cancer		Hemophilia		Stent Placement
	Cataracts		Hepatitis A, B, C		Sleep Disorders
	Chemotherapy		Herpes		Sinus Trouble
	Chest Pain		High Blood Pressure		Stroke
	Cold Sores/Fever Blisters		Hypoglycemia		Swelling of Limbs
	Congenital Heart Disorder		Kidney Problems		Thyroid Disease
	Convulsions		Liver Disease		Tuberculosis
	Cortisone Medicine		Lupus		Ulcers
	Diabetes I or II		Low Blood Pressure		Venereal Disease
	Drug Addiction		Lung Disease		Yellow Jaundice

Do you have any disease, condition or problem not listed above? Please explain: ____________________
____
____

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:***

____ ____________________

Review by: Doctor _________________________ Date:____________________ BP: ____________