BOGDAN FAMILY DENTISTRY

Bogdan Medical History V5-3

Patient Name: Birth Date:

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.

Primary Care Physician	◯ Yes ◯ No	If yes	
Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Have you ever been told to take an antibiotic before dental treatment?	◯ Yes ◯ No	If yes	
Have you ever been on medication for osteoporosis?	◯ Yes ◯ No	If yes	
Do you smoke, chew or vape?	◯ Yes ◯ No	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Comments:	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to become pregnant? ☐ Nursing? ☐ Using contraceptives?

Are you allergic to any of the following?

☐ Penicillin/Amoxicillian ☐ Codine ☐ Clindamycin ☐ Local Anthestics

☐ Latex

Other? ◯ Yes ◯ No If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Alzheimer's/ Dementia ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No
Hepatitis A, B or C ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Herpes ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No
Artificial Heart Valve/Stents ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No
Inhaler ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Acid Reflux ◯ Yes ◯ No
Difficulty Breathing ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No
Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No
Defibrilator/ Pacemaker ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Sexually Trans. Disease ◯ Yes ◯ No	Breast Implant ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Congenital Heart Disease ◯ Yes ◯ No		

If you have had cancer, please specify the type	◯ Yes ◯ No	If yes
Have you ever had a serious illnes not listed above?	◯ Yes ◯ No	If yes