vh dental

Medical History

Andrew M. Van Haren, DDS
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Name _____ Preferred Name_____ Birth Date _____ Age_____
Address _____ Email _____
Cell Phone _____ Home Phone _____ Work Phone _____
Emergency Contact _____ Phone _____ Relationship _____

Primary Care Physician _____ Most recent physical exam_____ Purpose_____
List any specialists providing you care_____
What is your estimate of your general health: (Circle) Excellent Good Fair Poor

Are you required to Pre-Medicate before dental treatment? Yes No Type of antibiotic you take for premed: _____

DO YOU HAVE or HAVE YOU EVER HAD or ARE YOU BEING TREATED FOR: *(Additional space provided on back for further explanation)*

Hospitalization within past 5 years Explain:	Yes	No	Osteoporosis/Osteopenia: If so, circle medications below: Fosamax Zometa Actonel Boniva Other: _____	Yes	No
Heart problems or cardiac stent	Yes	No	Arthritis: (Circle) Osteo Rheumatoid	Yes	No
History of Endocarditis	Yes	No	Autoimmune disease: (Circle) RA Lupus Scleroderma	Yes	No
Artificial heart valve or repaired heart defect (PFO)	Yes	No	Stomach or duodenal ulcer	Yes	No
Pacemaker or implantable defibrillator	Yes	No	Digestive disorders: (Circle) Celiac Disease, Gastric Reflux	Yes	No
Joint Replacement: (Circle) Knee Hip Right Left	Yes	No	Rheumatic or Scarlet Fever (Circle)	Yes	No
High blood pressure: If so, what is it usually? _____	Yes	No	Epilepsy, convulsions (seizures) Type: _____	Yes	No
Is your high blood pressure controlled? Yes or No			Depression or Anxiety	Yes	No
Low blood pressure: If so, what is it usually? _____	Yes	No	ADD or ADHD	Yes	No
Stroke	Yes	No	Viral infections or cold sores	Yes	No
Are you taking blood thinners?	Yes	No	STI/STD/HPV	Yes	No
Prolonged bleeding due to slight cut (INR>3.5)	Yes	No	Hepatitis: (Circle Type) A B C	Yes	No
Diabetes: (Circle) I II Gestational HbA1c = _____	Yes	No	HIV/AIDS	Yes	No
High cholesterol or taking statin drugs	Yes	No	Tumor, abnormal growth	Yes	No
Anemia or other blood disorder	Yes	No	Cancer : Please Explain type and stage:	Yes	No
Tuberculosis	Yes	No	Chemotherapy or Radiation Therapy (Circle)	Yes	No
Asthma If so, do you use an inhaler? Yes or No	Yes	No	Immunosuppressive medications	Yes	No
What induces your attacks? _____			Sleep Apnea (OSA) or snoring	Yes	No
Emphysema or shortness of breath	Yes	No	Do you use a CPAP? Yes or No		
Kidney Disease (ESRD)	Yes	No	Recreational drug use	Yes	No
Liver Disease: (Circle) Cirrhosis Jaundice	Yes	No	A smoker: How many per day? _____ Years? _____	Yes	No
Thyroid, Parathyroid Disease, or calcium deficiency (Circle)	Yes	No	A previous smoker: How many years? _____	Yes	No
Hormone deficiency	Yes	No	Use smokeless tobacco: How many years? _____	Yes	No
Glaucoma	Yes	No	Female: Are you taking birth control pills?	Yes	No
Experiencing frequent headaches or migraines	Yes	No	Female: Are you pregnant?	Yes	No
Taking dietary supplements	Yes	No	Female: Is there a possibility that you could be pregnant?	Yes	No
Male: prostate disorders?	Yes	No	Being treated for other illness: Please explain:	Yes	No

Do you have any known drug allergies? Yes or No Please circle all that apply:

Aspirin Ibuprofen Acetaminophen Codeine Penicillin Sulfa Metals (Nickel, Gold)
Erythromycin Tetracycline Local anesthetic Gluten Keflex Epinephrine
Other Antibiotics: _____ Other Allergies: _____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment: *(Additional space on back)*

_____

List all prescriptions and over the counter medications, supplements, and/or vitamins you are taking and the drugs purpose OR provide an accurate list with dose and reason for medication: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please advise us in the future of any change in your medical history or any medications you may be taking.
I certify to the best of my knowledge the above info is complete and accurate.

Patient's Signature_____Date _____

Doctor's Signature_____Date _____

ASA Classification: (For Office Use Only) I II III IV

Please provide any further explanation about your medical or dental health:

____
____
____
____
____
____

Additional space for medications, supplements, and/or vitamins:

____
____
____
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____
____

FOR OFFICE USE ONLY

Doctor Notes:

____
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____

Review of Medical History:

Date: __________ Change in Health Status: (Circle) Yes No Explain: ______________________________
List any medication changes: ____

Patient Signature: ______________________________ Doctor's Initials: __________

Date: __________ Change in Health Status: (Circle) Yes No Explain: ______________________________
List any medication changes: ____

Patient Signature: ______________________________ Doctor's Initials: __________

Date: __________ Change in Health Status: (Circle) Yes No Explain: ______________________________
List any medication changes: ____

Patient Signature: ______________________________ Doctor's Initials: __________

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List any medication changes: ____

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