HP DENTISTRY – Dr Pasnikowska

MEDICAL HISTORY FORM DATE:_____
(PLEASE PRINT CLEARLY)

Patient Name (Last, First, Middle Initial): _____
Preferred Name: _____
Date of Birth: _____ Male/Female Height: _____ Weight: _____
Phone Numbers: CELL_____ HOME _____ DAY_____
Address: _____
City: _____State: _____Zip:_____
Occupation:_____ E-Mail Address: _____
Martial Status: Single _____ Married _____ Widowed _____ Partnered _____ Divorced _____
Responsible Party: _____ Social Security: _____
Emergency Contact: _____
Billing address (if different from above):_____
Parents' names if patient is a minor: _____
If completing this form for another person, what is your relationship to them? _____
Who can we thank for referring you to Dr. Pasnikowska? _____

FOR THESE QUESTIONS CIRCLE YES OR NO AND ADD NOTES IF NECESSARY

Are you in good health? ..... Yes No
Date of last physical exam: _____
Are you under the care of a doctor at this time? ..... Yes No
If yes, for what condition? _____ Yes No
Physician's name: _____Phone: _____
His/Her address: _____
Have you had any serious illness, operation, or been hospitalized in the past 5 years? ……Yes No
If yes, for what? _____
Are you taking any medication now including nonprescription medication…… Yes No
List ALL medications: (Please include all prescription and non-prescription)

_____
_____
_____

Do you have or have you had any of the following diseases or problems?

Damaged Heart Valves or Artificial Valves? ..... Yes No
Heart Murmur or Rheumatic Heart Disease? …… Yes No
Infective Endocarditis or Congenital Heart Defects? …… Yes No
Cardiovascular Disease, Heart Trouble, or Heart Attack? ……. Yes No
Angina, Coronary Insufficiency, or Coronary Occlusion? ……..…… Yes No
High Blood Pressure, Arteriosclerosis or Stroke? ……. Yes No
Do you have a PACEMAKER? ..... Yes No
Do you have chest pain upon exertion? .....Yes No
Are you ever short of breath after mild exertion? .....Yes No
Have you had an allergic reaction to PENICILLIN or Other Antibiotics? …….. Yes No
If yes, to what:_____
Are you Allergic to Sulfa Drugs? ..... Yes No

Are you Allergic to Barbituates, Sedatives or Sleeping Pills? ..... Yes No
Are you Allergic to PABA? ..... Yes No
Are you Allergic to LATEX? ..... Yes No
Are you allergic to any other medication? ..... Yes No
If yes, to what? _____
Do you have any ARTIFICIAL JOINTS? ..... Yes No
If yes, what joint and when was it placed? _____
Do you have Sinus Trouble? ..... Yes No
Respiratory problems, Emphysema, or Bronchitis? ..... Yes No
Asthma or Hay Fever? ..... Yes No
Arthritis or Swollen Joints? ..... Yes No
Fainting Spells or Seizures? ..... Yes No
Stomach Ulcers? ..... Yes No
Persistent Diarrhea or Recent Weight Loss? ..... Yes No
Diabetes? ..... Yes No
Hepatitis, Jaundice or Liver Disease? ..... Yes No
AIDS or HIV? ..... Yes No
Thyroid Problems? ..... Yes No
Kidney Trouble? ..... Yes No
Tuberculosis? ..... Yes No
Persistent Cough or Cough Producing Blood? ..... Yes No
Persistent Swollen Glands in Neck? ..... Yes No
Low Blood Pressure? ..... Yes No
Sexually Transmitted Disease? ..... Yes No
Epilepsy or Neurological Disease? ..... Yes No
Mental Health Problems? ..... Yes No
Cancer? What kind? _____ Yes No
Immune System Problems? ..... Yes No
Do you Bleed Abnormally? ..... Yes No
Have you ever had a Blood Transfusion? ..... Yes No
Are you Anemic? ..... Yes No
Have you ever had a Tumor or Growth? ..... Yes No
Are you PREGNANT? ..... Yes No
Do you have any problems with your menstrual period? ..... Yes No
Do you take birth control pills? ..... Yes No
Do you take bisphosphonates (Actonal, Fosamax, Boniva or Forteo) for osteoporosis? ..... Yes No
Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
If yes, please explain: _____
_____
Is there anything not listed above that you would like doctor to be aware of? ..... Yes No
If yes, please explain: _____

I certify that I have read, understood and answered the questions to the best of my ability, and will not hold Dr. Pasnikowska or her staff responsible for any errors I may have made in filling out this form.

Sign _____Date_____