

Michael L. La Puma, D.M.D.
MEDICAL/DENTAL HEALTH HISTORY

Patient Name _____ Age _____

Date of Birth _____ Height _____ Weight _____

Occupation _____

If you are completing this form for another person, what is your relationship to that person?

Please Check an Answer for each Question Below:

1. Are you in good health?.....	Yes	No	
2. Are you now, or have you been, under the care of a physician during the past five years (not including annual exams)?.....	Yes	No	
3. Date of last dental exam? _____ Date of last medical exam? _____			
4. Have you ever been a patient in a hospital ?.....	Yes	No	
Reason for and approximate dates of hospitalizations:			

5. Have you taken any drugs or medications in the past year?	Yes	No	◆
Please list medications and dosages you are taking now or attach your own list:			

6. Have you ever used any blood thinner medications?	Yes	No	◆
7. Have you ever used the diet aide "Phen-Fen"?	Yes	No	
8. Have you ever used any of the bisphosphonate bone density enhancing medications? (Fosamax).....	Yes	No	
9. Do you have any allergies or sensitivities to medications? Please List:	Yes	No	◆

9a. Do you have an allergy to latex?	Yes	No	◆
10. Have you had local anesthesia? (numb)	Yes	No	
11. Have you had general anesthesia? (sleep)	Yes	No	◆
12. Do you now or have you ever used any device to help you breath during sleep? (C-Pap)...	Yes	No	◆
13. Are you subject to excessive bleeding?	Yes	No	
14. Do you have, or have you had, any of the following problems?			
a. Pain in chest upon exertion	Yes	No	
b. Short of breath after mild exercise.....	Yes	No	
c. Ankles swell	Yes	No	
d. Short of breath when lying down, or requiring an extra pillow when sleeping	Yes	No	
15. Do you have difficulty opening your mouth widely?	Yes	No	
16. Have you ever had an injury to the face or jaws?	Yes	No	
17. Do you have any numbness or tingling sensations in any part of your body?	Yes	No	
18. Have you ever received any radiation, chemotherapy, or surgical treatment for a tumor, growth, or other condition about your head, mouth, lips, or other parts of your body?	Yes	No	
19. Are you on dialysis?	Yes	No	
20. Do you wear contact lenses? How many:_____	Yes	No	
21. Do you have a cough, cold, or sinus problem at present?	Yes	No	
22. Are you a cigarette smoker?	Yes	No	
23. Do you chew tobacco?	Yes	No	

24. Women:

- a. Are you pregnant? Yes No
 b. If so, how many months?
 c. Are you nursing? Yes No
 d. Are you taking birth control pills? Yes No

25. Please Check an Answer for Each Condition Below:

Heart Failure	Yes	No
Heart Disease or Attack	Yes	No
Angina Pectoris (Chest Pain)	Yes	No
High Blood Pressure	Yes	No
Heart Murmur	Yes	No
Rheumatic Fever	Yes	No
Damaged Heart	Yes	No
Artificial Heart Valves	Yes	No
Mitral Valve Prolapse	Yes	No
Heart Surgery	Yes	No
Artificial Joint	Yes	No
Anemia	Yes	No
Stroke	Yes	No
Kidney Trouble	Yes	No
Ulcers	Yes	No
Bruise Easily	Yes	No
Emphysema	Yes	No
Cough	Yes	No
Tuberculosis (TB)	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Sinus Trouble	Yes	No
Allergies or Hives	Yes	No
Sickle Cell Disease	Yes	No

Malignant Hyperthermia	Yes	No
Diabetes	Yes	No
Thyroid Disease	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Arthritis	Yes	No
Cortisone Medicine	Yes	No
Glaucoma	Yes	No
Pain in Jaw	Yes	No
Hepatitis A (Infectious)	Yes	No
Hepatitis B (Serum)	Yes	No
Liver Disease	Yes	No
AIDS/HIV Positive	Yes	No
Yellow Jaundice	Yes	No
Blood Transfusion	Yes	No
Drug or Alcohol Problems	Yes	No
Hemophilia	Yes	No
S.T.D. or S.T.I. (Syphilis, Gonorrhea, Herpes)	Yes	No
Cold Sores	Yes	No
Epilepsy or Seizures	Yes	No
Fainting or Dizzy Spells	Yes	No
Nervousness	Yes	No
Psychiatric Treatment	Yes	No

26. Do you have **any disease, condition, or problem** not listed above that you think we should know about? If so, please explain: Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or my medicines change, I will inform the doctor at the next appointment without fail.

Signature of Patient, Parent, or Guardian: _____ Date: _____

OFFICE USE

Reviewed by (Doctor): _____ Date: _____

B/P P R

Date	Additions/Changes	Pt. Initials	Review By (Dr.)	Vital Signs (B/P P R)