**MESA DENTAL GROUP**

PATIENT MEDICAL HISTORY

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 medications you may be taking could have an important interrelationship with the dentistry you will be receiving. Thank you for answering the following questions.

1.Are you in good health…………….YES NO 9. Do you Bruise Easily?......................YES NO

2.Have there been any changes in your general 10.Have you ever required a blood transfusion?.. YES NO

Health in the past year…………………………YES NO 11.Have you had a recent weight lost?..........YES NO

3.Date of your last physical Exam 12.Have you ever taken Fen-Phen or Redux? YES NO

4.Name of Physician: 13.Do you use tobacco?.................................YES NO

5.Phone Number: 14.Do you/have you used controlled substances? YES NO

6.Have you ever been hospitalized for any 15.Are you wearing contact lenses?.............YES NO

Surgical procedures or serious illness? YES NO 16.Do you have any disease, condition or problem,

Please Explain: not listed above that you think we should know about?

 …………………………………………………………………YES NO

7.Are you taking any medicine(s)including any

Non-prescription medicine……………….YES NO **WOMEN ONLY QUESTIONS #1-#3**:

If yes what: 1.Are You/think you may be pregnant?...........YES NO

 2.Are you nursing?...........................................YES NO

8.Have you had any abnormal bleeding?..YES NO 3.Are you taking birth control?........................YES NO

**ARE YOU ALLERGIC OR HAVE YOU HAD REACTIONS TO:**

Local anesthetic like Novocaine………………………….YES NO Penicillin or other antibiotics………………………….YES NO

Sulfa Drugs…………………………………………………………YES NO Barbiturates, sedatives or sleeping pills………….YES NO

Aspirin………………………………………………………………YES NO IODINE…………………………………………………………....YES NO

Any Metals(E.G., Nickel, Mercury,ETC.)………………YES NO Latex/Rubber…………………………………………………..YES NO

Other Please List:

**DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:**

Rheumatic fever or rheumatic heart disease………YES NO Scarlet Fever…………………………………………………..YES NO

Heart defect or heart murmur…………………………….YES NO Chest………………………………………………….…………..YES NO

Heart trouble, heart attack or angina………………….YES NO Mitral valve prolapse………………………………………YES NO

Shortness of breath…………………………………………….YES NO Pacemaker……………………………….……………………..YES NO

Heart Surgery……………………………………………………..YES NO High or Low Blood Pressure………………….………...YES NO

Congenital heart problems…………………………………YES NO Hepatitis TYPE …………………………………………YES NO

Asthma………………………………………………………………YES NO Diabetes………………………………………………..………..YES NO

Fainting or dizzy spells……………………………………….YES NO AIDS or HIV infection………………………………………YES NO

Thyroid problems………………………………………………YES NO Allergies………………………………………………………….YES NO

Arthritis or rheumatism………………………………….…YES NO Joint replacement or implant………………………….YES NO

Stomach ulcer……………………………………………….….YES NO Kidney Trouble………………………………………….……YES NO

Tuberculosis………………………………………………….….YES NO Chemotherapy(cancer, leukemia)………………..….YES NO

Sexually transmitted disease……………………….……YES NO Epilepsy or seizures…………………………………..…….YES NO

Anemia………………………………………………………….….YES NO Glaucoma………………………………………………………..YES NO

Sinus Trouble…………………………………………….……..YES NO Nervousness……………………………………………………YES NO

Tumors……………………………………………….………..….YES NO Mental Health Care………………………………………….YES NO

Back Problems………………………………………….……..YES NO Chemical Dependency………………………………………YES NO

Hypoglycemia………………………………….………………YES NO Eating disorders………………………………………………..YES NO

Cold sores or fever blisters………………………………YES NO

**Patient Signature: Date:**