Time 1:11 PM | James M. Stuart, DDS, PA | Date 12/7/2023

Medical History

Patient Name: | Birth Date: | Date Created:

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.

Do you have any medical conditions for which you are presently undergoing treatment?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation? Please provide estimated date.	◯ Yes ◯ No	If yes
Are you taking any prescripton medications? Please list drug (s) and reason for taking.	◯ Yes ◯ No	If yes
Additional medications:	◯ Yes ◯ No	If yes
Have you ever taken bone density medications such as Fosamax, Boniva or Actonel? Provide dates:	◯ Yes ◯ No	If yes
Do you use tobacco? What type and how often?	◯ Yes ◯ No	If yes

Use of drugs and or alcohol can significantly affect your dental health and treatment needs. Please discuss this with Dr. Stuart in confidence (and without judgement) so we can take the best possib

Are you allergic to any of the following?

Aspirin	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No
Codeine	◯ Yes ◯ No	Latex	◯ Yes ◯ No
Sulfa Drugs	◯ Yes ◯ No	Local Anesthetics	◯ Yes ◯ No

Other Allergies: ◯ Yes ◯ No If yes

Have you ever had a heart attack? Please provide date: ◯ Yes ◯ No If yes

What treatment was provided?

☐ Stent(s)	☐ Arteroplasty
☐ By-Pass	☐ Daily Medication

Do you have High Blood Pressure? Please list medications:	◯ Yes ◯ No	If yes
Do you have chest Pain/Angina? Do you take Nitroglycerine for this? how often do you experience?	◯ Yes ◯ No	If yes
Do you have a pacemaker? Please provide date:	◯ Yes ◯ No	If yes

Please check if you have any other heart problems or conditions:

Mitral Valve Prolapse	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Scarring from Rheumatic/Scarlett Fever	◯ Yes ◯ No
Irregular Heart Beat	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No

Have you ever been told that you need to pre-medicate before having dental treatment? Reason: ◯ Yes ◯ No If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Chemotherapy/Radiation	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Acid Reflux	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Opiod Addiction	◯ Yes ◯ No	HPV	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Women: Are you....

Pregnant	◯ Yes ◯ No	Trying to get pregnant	◯ Yes ◯ No
Nursing	◯ Yes ◯ No	Taking oral contraceptives	◯ Yes ◯ No

Additional comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____