Howard F. Cooke, D.M.D., M.S.

MEDICAL HISTORY FORM

Patient Name _____ **Today's Date** _____

Date of Birth_____ Age: _____ Sex: M / F Height:_____Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
6. Have you had any serious illness, operation or hospitalization within the past 10 years? ..... Yes No
   _____
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? ..... Yes No
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Rheumatic Heart Disease ..... Yes No
   c. Heart trouble ..... Yes No
      1. Heart attack ..... Yes No
      2. Angina ..... Yes No
      3. High blood pressure ..... Yes No
      4. Stroke ..... Yes No
      5. Arteriosclerosis ..... Yes No

      or any other heart condition including pacemaker or defibrillator ..... Yes No
      1. Chest pain upon exertion? ..... Yes No
      2. Shortness of breath after mild exercise? ..... Yes No
      3. Do your ankles swell? ..... Yes No
   d. Allergies ..... Yes No
   e. Sinus trouble ..... Yes No
   f. Asthma or hay fever ..... Yes No
   g. Fainting spells or seizures ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice or liver disease ..... Yes No
   j. Frequent or recurring mouth sores ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, COPD, etc. ..... Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
   n. Osteoporosis ..... Yes No
   o. Stomach ulcer or hyperacidity ..... Yes No
   p. Kidney trouble ..... Yes No
   q. Tuberculosis ..... Yes No

Patient Name: _____ Today's Date: _____

r. Persistent cough or cough that produces blood ..... Yes No
s. Persistent swollen neck glands..... Yes No
t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer..... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system..... Yes No
x. Anxiety, Depression or any other mental disorder..... Yes No

10. Have you had abnormal bleeding?..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
11. Do you have any blood disorder such as anemia? ..... Yes No
12. Have you ever had treatment for a tumor or growth? ..... Yes No
13. Have you had radiation therapy to the head, neck or jaws?..... Yes No
14. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain:_____
    _____
15. Do you have any other condition or disease you think the doctor should know about?..... Yes No
    If so, explain:_____
16. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____
17. Is there any past history of alcohol or chemical dependency or emotional disorder
    that may affect the care we provide you? ..... Yes No
18. Do you have sleep apnea or use/have you ever used a c-pap machine..... Yes No
19. Are you wearing removable dental appliances? ..... Yes No
20. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

21. Are you pregnant or trying to become pregnant ..... Yes No
22. Do you have problems associated with your menstrual period? ..... Yes No
23. Are you nursing?..... Yes No
24. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint: _____
_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

_____

Patient Signature/Date

Patient Name: _____ Today's Date: _____

MEDICATIONS: Are you allergic to, sensitive to, or had a bad reaction to: (Circle Yes or No)

Local Anesthetic (Novocaine, etc.)	Yes	No	Aspirin/Ibuprofen	Yes	No
Penicillin/Amoxicillin	Yes	No	Codeine	Yes	No
Latex/Rubber Products	Yes	No	Sulfa	Yes	No
Barbiturates/Sedatives	Yes	No	Eggs	Yes	No

List any other medications you are allergic to: _____

_____

_____

_____

ARE YOU USING OR TAKING ANY OF THE FOLLOWING? (Circle Yes or No)

Tagamet	Yes	No	Other Heart Medicine _____	Yes	No
Antibiotics or Sulfa Drugs	Yes	No	Fosamax, Boniva or Actonel	Yes	No
High Blood Pressure Medications	Yes	No	Thyroid Medications	Yes	No
Tranquilizers (Valium, Anti-Depressants)	Yes	No	Anticoagulants (Blood Thinners)	Yes	No
Antihistamines or Decongestants (Seldane)	Yes	No	Steroids (Cortisone, etc.)	Yes	No
Aspirin or Ibuprofen (Motrin, Naprosyn, etc.)	Yes	No	Insulin, Diabetes, Similar Drugs	Yes	No
Digitalis, Inderal, Nitroglycerin, Calcium Channel Blockers, Procardia	Yes	No	Weight Loss Medications If yes, how much daily? _____	Yes	No

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescriptions and over-the-counter medications (i.e. aspirins, antacids), herbal supplements (i.e. ginseng, gingko). Include all medications taken as needed (i.e. nitroglycerin, inhalers, and allergy medications).

Name of Medication	Dosage / amount	When do you take it?	Purpose of Medication	