Manyak Dental Group
650-342-9941

Medical History

PATIENT NAME: ______________________ **Date of Birth:** ______________

How is your general health? ______________________

Has there been a change in your health in the past year? No Yes: ______________

Have you been hospitalized or had a serious illness in the past three years? Yes / No
If YES, please describe: ______________________

Are you currently being treated by a physician? Yes / No If YES, for what? ______________

Date of last Medical exam: ______________ Physician's Name: ______________

Date of last Dental appointment: ______________ Are you in pain now? Yes / No

Have you had problems with prior dental treatment? Yes / No

Have you ever had to premedicate prior to dental treatment? Yes / No

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

1. Yes No Chest Pain (Angina)?
2. Yes No Swollen ankles?
3. Yes No Shortness of Breath?
4. Yes No Recent weight loss, fever or night sweats?
5. Yes No Persistent cough or coughing up blood?
6. Yes No Bleeding problems, easy bruising?
7. Yes No Sinus problems?
8. Yes No Difficulty swallowing?
9. Yes No Diarrhea, constipation or blood in stool?
10. Yes No Frequent vomiting or nausea?
11. Yes No Difficulty urinating or blood in urine?
12. Yes No Dizziness?
13. Yes No Ringing in ears?
14. Yes No Headaches?
15. Yes No Fainting spells?
16. Yes No Blurred vision?
17. Yes No Seizures?
18. Yes No Excessive thirst?
19. Yes No Frequent urination?
20. Yes No Dry mouth?
21. Yes No Jaundice?
22. Yes No Joint pain or stiffness?

DO YOU HAVE OR HAVE YOU HAD:

23. Yes No Heart Disease?
24. Yes No Heart attack or heart defects?
25. Yes No Heart murmurs?
26. Yes No Rheumatic Fever?
27. Yes No Stroke or hardening of arteries?
28. Yes No High blood pressure?
29. Yes No TB, emphysema, asthma or other lung disease?
30. Yes No Hepatitis or other liver disease?
31. Yes No Stomach problems or ulcers?
32. Yes No Allergies to food or medications?
    Please List: ______________________
33. Yes No Allergies to metal?
    Please List: ______________________
34. Yes No Family history of diabetes, heart problems, tumors?
35. Yes No Psychiatric care?
36. Yes No Radiation treatments?
37. Yes No Chemotherapy?
38. Yes No Prosthetic heart valve?
39. Yes No Artificial joint?
40. Yes No Hospitalization?
41. Yes No Immunodeficiency (HIV, AIDS, etc.)?
42. Yes No Tumors or Cancer?
43. Yes No Arthritis or rheumatism?
44. Yes No Eye diseases?
45. Yes No Skin disease?
46. Yes No Anemia?
47. Yes No Sexually transmitted infections?
48. Yes No Herpes?
49. Yes No Kidney or bladder disease?
50. Yes No Thyroid or adrenal disease?
51. Yes No Diabetes?
52. Yes No Blood transfusions?
53. Yes No Surgeries?
54. Yes No Pacemaker?
55. Yes No Osteoporosis?
56. Yes No Latex allergy?
57. Yes No Eating disorder?

ARE YOU TAKING OR HAVE YOU EVER TAKEN:

58. Yes No Recreational Drugs?
59. Yes No Bisphosphonates (e.g. Fosamax)?
60. Yes No Tobacco in any form?
61. Yes No Alcohol?
62. Yes No Birth Control Pills?
63. Yes No Weight loss medications?

Please list your current medications (including over-the-counter medications like aspirin):

____

____

OTHER:

64. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
    Please List: ______________________
    ____
65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Have you EVER taken the diet pills Fen-phen, Redux or Pondimin?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health or any changes in medication. Permission is given for dental treatment as agreed upon and to use local anesthetics, analgesics, sedatives and x-rays as deemed necessary by the doctor. I will not hold the dentist or any member of her/his staff responsible for any errors or omissions that I may have made in completion of this form.

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Patient's signature: ______________ Dr. sign. ______________ Date: ______________