**Medical History** for ALL patients of **JOSÉ A. SAPIA, DMD**

\*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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Who is your primary care Doctor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had major surgery or been hospitalized in the last 5 years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had a serious head or neck injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications, vitamins or aspirin? Please list ALL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take a premedication prior to dental treatment? Why and what med? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you smoke or chew tobacco?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women:** Are you…

□ Pregnant? □ Nursing? □ Taking Oral Contraceptives?

**Allergies:**

□ None Known □ Aspirin □ Penicillin □ Codine □ Acrylic

□ Metal □ Latex □ Sulfa □ Local Anesthetics

Please list any other allergies not listed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following? Please check ALL that apply:

□ AIDS/HIV Positive □ cortisone Medicine □ Hemophilia □ Radiation Treatments

□ Alzheimer’s Disease □ Diabetes □ Hepatitis A □ Recent Weight Loss

□ Anaphylaxis □ Drug Addiction □ Hepatitis B or C □ Renal Dialysis

□ Anemia □ Easily Winded □ Herpes □ Rheumatic Fever

□ Angina □ Emphysema □ High Blood Pressure □ Rheumatism

□ Arthritis/Gout □ Epilepsy □ High Cholesterol □ Scarlet Fever

□ Artificial Heart Valve □ Excessive Bleeding □ Hives or Rash □ Shingles

□ Artificial Joint □ Excessive Thirst □ Hypoglycemia □ Sickle Cell Disease

□ Asthma □ Fainting Spells/Dizziness □ Irregular Heartbeat □ Sinus Trouble

□ Blood Disease □ Frequent Cough □ Kidney Problems □ Spinal Bifida

□ Blood Transfusion □ Frequent Diarrhea □ Leukemia □ Stomach Disease

□ Breathing Problems □ Frequent Headaches □ Liver Disease □ Stroke

□ Bruise Easily □ Genital Herpes □ Low Blood Pressure □ Swelling of Limbs

□ Cancer □ Glaucoma □ Lung Disease □ Thyroid Disease

□ Chemotherapy □ Hay Fever □ Mitral Valve Prolapse □ Tonsillitis

□ Chest Pains □ Heart Attack/Failure □ Osteoporosis □ Tuberculosis

□ Cold Sores/Fever Blisters □ Heart Murmur □ Pain in Jaw Joints □ Tumors or Growths

□ Congenital Heart Disorder □ Heart Pacemaker □ Parathyroid Disease □ Ulcers

□ Convulsions □ Heart Trouble/Disease □ Psychiatric Care □ Venereal Disease

Please list any serious illness or condition you have/had not listed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\*All questions on this form have been answered accurately and it is my responsibility to update my medical status.