

Melissa A. Hamilton, DMD
Patient Information

Date: _____

Name: _____ **Date of Birth** _____

Address: _____

City, State, Zip Code: _____

If we need to contact you between 8:30am-5:00pm, which number should we call?

Please circle: Home Work Other (Cell phone, pager) _____

Home Phone: _____ **Work Phone** _____

Social Security Number _____ **Sex: M__F__**

Patient's Employer: _____

Employer's Address: _____

City, State, Zip Code: _____

Name of School (if student) _____

Nearest Relative

Name: _____ **Relationship** _____

Address (if different from patient): _____

City, State, Zip Code _____ Phone: _____

Name of Insured: (if different from patient) _____

Relationship: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____

Address: _____ Phone Number: _____

Name of Dental Insurance: _____

ID Number: _____ **Group Number** _____

Name of Medical Insurance: _____

ID Number: _____ **Group Number** _____

Name of Referring Dentist/Doctor: _____

Medical History

1. Patient Name: _____
Name of Medical Doctor: _____
Telephone Number: _____

2. Date of last physical exam _____
3. Are you in good health?..... yes or no
4. Has there been any change in your general health in the past year? yes or no
5. Are you now under a physician's care for a particular problem? yes or no
If yes, what?

6. Have you had any serious illness, operations, or hospitalizations?....yes or no
If so, what? _____
7. Have you had any adverse effects from dental treatment?.....yes or no
8. Do you have, or have you ever had:
 - a. Rheumatic fever or rheumatic heart disease?.....yes or no
 - b. Congenital heart disease?.....yes or no
 - c. Crdiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)?.....yes or no
 - d. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)..... yes or no
 - e. Seizures convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder, or breakdown)?.....yes or no
 - f. Bleeding disorder, anemia, bleeding tendency, blood transfusion. (do you bruise easily)?.....yes or no
 - g. Liver disease (jaundice or hepatitis)?.....yes or no
 - h. Kidney disease?.....yes or no
 - i. Diabetes?.....yes or no
 - j. Thyroid disease(Goiter)?.....yes or no
 - k. Arthritis?.....yes or no
 - l. Stomach ulcers or colitis?.....yes or no
 - m. Glaucoma?.....yes or no
 - n. Implants placed anywhere (hip, knee, heart valve).....yes or no
 - o. Radiation (x-ray) treatment for cancer?..... yes or no
 - p. Clicking or popping of jaw joint, pain near the ear, difficulty opening the mouth, grind or clench the teeth?.....yes or no
 - q. Sinus or nasal problems?.....yes or no
 - r. Any disease, drugs, or transplant operation that has depressed your immune system (steroids, cortisone).....yes or no
 - s. Recurrent infections of any kind?.....yes or no
9. Are you using or taking any of the following medications?
 - a. Tagamet?.....yes or no

- b. Thyroid medications?.....yes or no
 - c. Antibiotics or sulfa drugs?.....yes or no
 - d. Anticoagulants (blood thinners)?.....yes or no
 - e. Steroids (cortisone, prednisone)?.....yes or no
 - f. High blood pressure medicines?.....yes or no
 - g. Tranquilizers (valium, etc.)?.....yes or no
 - h. Insulin, diabenese, or similar drugyes or no
 - i. Digitalis, inderal, nitroglycerin, calcium channel blockers, procardia, or other heart medicine.....yes or no
 - j. Aspirin or ibuprofen (motrin, naprosyn, etc.)?yes or no
 - k. Marijuana or other “street” drugs?.....yes or no
 - l. Antihistamines or decongestants?.....yes or no
 - m. Are you taking any other regular medications or drugs?.....yes or no
If yes, please list _____
10. Are you allergic or had a bad reaction to:
- a. Local anesthesia (novacaine, etc.)..... yes or no
 - b. Penicillin, amoxicillin, cephalosporins, other antibiotics?.....yes or no
 - c. Barbituates, sedatives, etc.yes or no
 - d. Aspirin or ibuprofen.....yes or no
 - e. Codeine or other pain killers..... yes or no
 - f. Latex or rubber products.....yes or no
 - g. Other allergies or reactions.....yes or no
- If yes, please list: _____
11. Do you smoke or chew tobacco?.....yes or no
How much daily? _____
12. Do you use alcohol?.....yes or no
How much? _____
13. Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders?..... yes or no
14. Women: Are you pregnant or planning pregnancy?.....yes or no
Are you taking birth control pills?.....yes or no
(Reduced efficacy of birth control medications has been associated with some of the medications used in the practice of oral & maxillofacial surgery.)
15. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?.....yes or no

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with the doctor.

Patient Name (Printed) _____ Date _____

Patient/Guardian Signature _____ Date _____

Doctors Signature: _____ Date _____