

ANNA M. MUNNE, DDS, PA
PATIENT MEDICAL HISTORY

Date _____ Patient Name _____

Height _____ Weight _____ D/O/B _____ Age _____

Do you smoke? Yes No Have you ever smoked? Yes No Quit _____
____cigarettes ____pipe ____chewing ____cigar ____snuff How much per day? _____
Alcohol use Yes No How many? _____ day/ week
Recreational drugs? Yes No Type _____ Frequency _____

Do you need pre-medication prior to a dental appointment? Y N Antibiotic used? _____

Current/Past Diseases

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Implant prosthesis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Frequent chest pains | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Lupus erythematosus | <input type="checkbox"/> Ulcers-gastritis | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hives/skin rash | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Venereal diseases | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Cortisone therapy | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Diseases in your family _____

Prescription Medication

Non- Prescription Medication

Have you ever taken Fosamax, Actonel, or Boniva? Yes No When did you start? _____
How long was it taken? _____ Date finished _____

Last Physical Exam _____ Physician's Name _____

Allergies to:

Prescription Drug Allergies _____

Non-Prescription Drug Allergies _____

Surgical History w/ dates _____

General Anesthesia Complications _____

FOR WOMEN ONLY

Are you pregnant now? Y N Trimester 1 2 3

Taking hormones/ birth control? _____

Have you reached menopause? Y N Have you had a hysterectomy? Y N

Are you anticipating pregnancy? Y N Are you breastfeeding? Y N

Gave birth to _____ children, ages _____

Did you have any complications during pregnancy? _____

Do you experience frequent yeast infections? Y N

Do you have any other disease, condition or problems not listed above that Anna Munne, DDS, PA should know about before proceeding with treatment? _____

I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE

DATE

X _____

X _____

X _____
