MEDICAL HISTORY

Today's Date ______________________________ Birthdate _________________________ ☐Female ☐ Male

Name ____
Last First Middle

Please indicate all conditions which apply to you past or present:

☐ Asthma
☐ Environmental Allergies
☐ Sinus problems
☐ Arthritis
☐ High blood pressure
☐ High Cholesterol
☐ Diabetes
☐ Stroke
☐ Heart disease
☐ Heart attack/Angina
☐ Mitral valve prolapse
☐ Heart murmur
☐ Pace maker
☐ Seizures/epilepsy
☐ Bleeding/clotting disorder
☐ Thyroid disorder
☐ Tuberculosis
☐ Lung disease
☐ Immune disorder
☐ Ulcers
☐ Headaches
☐ Osteoporosis/Osteopenia
☐ Kidney disease
☐ Liver disease
☐ Cancer
☐ Mental illness
☐ Anxiety/Depression
☐ Alcoholism
☐ Substance abuse

Current Medications (including supplements and over the counter medication)

Medication	Reason	Medication	Reason

Are you allergic to ☐ Latex, ☐ Dye, ☐ Bleach, ☐ Medication: ____

Do you take **osteoporosis** medication? ☐ Yes ☐ No If yes, how long? ____________________

Do you take **cancer** medication? ☐ Yes ☐ No If yes, how long? ____________________

Please list all Surgeries including Artificial Joints (year) ____

____

Do you require antibiotics prior to dental treatment due to **heart condition or artificial joint**? ☐ Yes ☐ No

If yes, what type of antibiotics and when did you take it? ____

Name and phone # of orthopedic specialist ____

Tobacco Products Usage: ☐ Current user #Packs/day ____# years ____. ☐ Quit: Year quit ____________. ☐ Never

☐ I am not ready to quit ☐ I am currently in a cessation program ☐ I would like information on quitting

Women: Do you think you might be pregnant? ☐ Yes ☐No

Dental History

Reason for your visit today ____

History of **this tooth** (fillings, crowns, Previous Root canal etc) ____

____

Please indicate all conditions which apply to **this tooth**:

☐ Toothache
☐ Gum disease
☐ Sensitive gums
☐ Sensitive teeth
☐ Pain to Cold
☐ Pain to Heat
☐ Pain on Chewing
☐ Pain on release
☐ Cavities
☐ Abscess in mouth
☐ Grinding/Clenching
☐ Pain in Jaw/TMD

Do you have special concerns regarding your visit? ☐ Fear ☐Time ☐ Money ☐ Stress ________________________________

Is there anything you would like to discuss with Dr. Adu-Sarkodie in private? ☐YES ☐ NO

I certify that the above is accurate and that I am responsible to notify this office of any changes in my health:

________________________________ ________________

Signature Patient or Patient Representative Date

________________________________ ________________

Dr. Signature Date