Tate Stimpson, D.M.D.

Family & Cosmetic Dentistry

Medical History

Patient Name: _____ Date of Birth: _____

Name and Phone Number of your physician/ Specialist. Please include medical number.

_____

Who should we contact in case of an emergency? Please provide phone numbers.

_____

1. Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
   If yes, please list: _____
2. Have you ever had a serious head or neck injury? ☐ Yes ☐ No
   If yes, please list: _____
3. Are you taking any medications, pills, or drugs? ☐ Yes ☐ No
   If yes, please list: _____
4. Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No
5. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
6. Do you use tobacco? If yes, what form? ☐ Yes ☐ No
   If yes, please list: _____
7. Have you been told by a physician that you need prophylactic antibiotics before dental treatment (Pre-mediation)? ☐ Yes ☐ No
8. Do you have any trouble laying back in a chair? ☐ Yes ☐ No
9. Do you gag easily? ☐ Yes ☐ No

Women: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are you allergic to any of the following:

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metals ☐ Latex

☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other _____

Do you use controlled substances? ☐ Yes ☐ No Please List: _____

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Medical History - Page 2

Patient Name: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes	☐ No	Breathing Problems	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No	Congenital Heart Disorder	☐ Yes	☐ No
Arthritis/Gout/Rheumatism	☐ Yes	☐ No	Convulsions	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Attack/Failure	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Stomach/Intestinal Disease	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Swelling of Limbs	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Hepatitis A, B or C	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Fainting Spells/Dizziness	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Parathyroid Disease	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Radiation treatments	☐ Yes	☐ No	Psychiatric Conditions	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No			

Have you ever had any serious illness not listed above? ☐ **Yes** ☐ **No**

Please list: _____

Additional Details:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I also acknowledge that I have received or had an opportunity to review the Notice of Privacy Practices as well as the Dental Materials Fact Sheet dated June 2004.

_____ _____

Signature of Patient, Parent or Guardian *Date*

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