Michael T Bodensteiner, D.D.S.

Patient Medical History- Dr. Bodensteiner

Patient Name: Birth Date: Date Created:

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

Doctors Use Only

Blood Pressure	◯ Yes ◯ No	If yes
O2 Saturation	◯ Yes ◯ No	If yes
Pulse	◯ Yes ◯ No	If yes

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized?	◯ Yes ◯ No	If yes
Have you ever had a head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications or pills?	◯ Yes ◯ No	If yes

Please List All Medications you currently are taking:

Have you ever taken Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel ?	◯ Yes ◯ No	If yes
Do you take Pre-medication before dental	◯ Yes ◯ No	If yes
Are you taking Antacids?	◯ Yes ◯ No	
Are you taking any Supplements?	◯ Yes ◯ No	If yes
Are you taking Biaxin (clarithromycin)?	◯ Yes ◯ No	
Do you consume grapefruit juice or grapefruits?	◯ Yes ◯ No	
Do you use tobacco? Cigarettes or Chew	◯ Yes ◯ No	If yes
Do you consume alcohol? how many per week?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Latex
☐ Sulfa Drugs	☐ Local Anesthetics	☐ Tylenol	☐ Valium
☐ Sedatives	☐ NSAIDS		

Other?	◯ Yes ◯ No	If yes
Do you use Recreational Drugs?	◯ Yes ◯ No	If yes
Do you use any Blood Thinners?	◯ Yes ◯ No	If yes
Do you have an artificial Heart Valve? When?	◯ Yes ◯ No	If yes
Do you Have a Congenital Heart Disorder?	◯ Yes ◯ No	
Have you had Endocarditis?	◯ Yes ◯ No	If yes
Do you have a Pacemaker?	◯ Yes ◯ No	If yes
Have you had a Heart Attack?	◯ Yes ◯ No	If yes
Have you had Heart Surgery?	◯ Yes ◯ No	If yes

Weight and Diet considerations

Weight	○ Yes ○ No	If yes	
Meals per Day	○ Yes ○ No	If yes	
Dietary Restrictions	○ Yes ○ No	If yes	
Food Allegies	○ Yes ○ No	If yes	
Sugar in your diet? Circle: none slight moderate	○ Yes ○ No	If yes	
Do you Have Jaw Pain?	○ Yes ○ No		
Do you Wear a Night Guard for Jaw Pain?	○ Yes ○ No		

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

AIDS/HIV Positive ARC ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No	Angina ○ Yes ○ No
Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No	Arthritis/Gout ○ Yes ○ No
Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No
Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No	Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No
Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No	Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No
Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No	Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No
Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No	Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No
Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No	Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No
Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No	Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No
Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No	Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No
Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No	Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No
Tonsillitis ○ Yes ○ No	Chest Pains ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Tumors or Growths ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No
Ulcers ○ Yes ○ No	Convulsions ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No	Sore/Enlarged Lymph Nodes ○ Yes ○ No	Slow-Healing Mouth Sores ○ Yes ○ No	Previous Biopsies ○ Yes ○ No
Organ Transplant ○ Yes ○ No			

Do you have a Heart Stent (s) When where they	○ Yes ○ No	If yes	
Have you ever had any illness not listed Above?	○ Yes ○ No	If yes	
Do you have Sleep Apnea?	○ Yes ○ No	If yes	
Do you use a CPAP?	○ Yes ○ No		

Comments

To the best of my knowledge, the questions on this form have been accurately answered.It is my responsibility to inform the dental office of any changes in medical

Signature of Patient, Parent or Guardian:

X Date:_____