

# Wayland Family Dental Center

## Personal Health Information

Please indicate previous and current medical conditions:

- Allergy to any medicines \_\_\_\_\_
- Allergy to latex or any other material \_\_\_\_\_
- Blood diseases \_\_\_\_\_
- Heart conditions listed below:
  - Prosthetic cardiac valves \_\_\_\_\_
  - Infective endocarditis \_\_\_\_\_
  - Cardiac transplant \_\_\_\_\_
  - Congenital heart disease (repairs made with shunts or other prosthetic material) \_\_\_\_\_
- Cancer \_\_\_\_\_
  - Radiation therapy?  Yes  No      Chemotherapy?  Yes  No
- Diabetes    Last tested blood sugar level \_\_\_\_\_ mg/dl    date of last test \_\_\_\_\_
- Epilepsy
- Gastrointestinal conditions \_\_\_\_\_
- History of Infectious disease (HIV, Hepatitis, TB etc...) \_\_\_\_\_
- Joint replacement therapy \_\_\_\_\_ date \_\_\_\_\_
  - Premedication advised prior to dental procedures?  Yes  No
- Kidney or Liver disease \_\_\_\_\_
- Musculoskeletal conditions or injuries / Jaw pain \_\_\_\_\_
- Osteoporosis
  - History of medicine to treat? (Actonel, Boniva, Fosamax, Reclast)  Yes  No
- Psychological conditions \_\_\_\_\_
- Respiratory conditions / Sleep apnea / Snoring \_\_\_\_\_
- Sinus difficulties
- Stroke      date of stroke \_\_\_\_\_
- Any other conditions or diseases not listed \_\_\_\_\_

## Physician Information

Primary Care Physician:

Name \_\_\_\_\_  
Number \_\_\_\_\_  
Location \_\_\_\_\_

Specialist:

Name \_\_\_\_\_  
Number \_\_\_\_\_  
Location \_\_\_\_\_

Please list all medicines you are currently taking

RX \_\_\_\_\_  
RX \_\_\_\_\_  
RX \_\_\_\_\_  
RX \_\_\_\_\_  
RX \_\_\_\_\_  
RX \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_