University of the Pacific, Arthur A. Dugoni School of Dentistry
Medical History

Patient Name_____ Birth Date_____ ID Number_____
(provided by UOP upon submission)

Today's Date _____

1. **Do you have any of the following diseases or problems?**
   a. Active Tuberculosis Yes / No
   b. Persistent cough greater than 3 weeks in duration Yes / No
   c. Cough that produces blood Yes / No
   d. Been exposed to anyone with Tuberculosis Yes / No
   e. Describe any Yes answers to above questions. _____

2. **What is your impression of your health?** Excellent, Good, Fair, Poor (circle)
   a. Date of last physical exam _____

3. **Are you now, or have you been in the past year, under the care of a physician?** Yes / No

4. **Have you had any serious illness, operation, or been hospitalized in the past 5 years?** Yes / No

5. **Have you had an organ transplant?** Yes / No

6. **Do you have a history of Endocarditis (infected heart valve)?** Yes / No

7. **Have you had open heart surgery?** Yes / No
   a. If yes, when was your heart surgery (year) _____
   b. Was an artificial heart valve implanted? Yes / No
   c. Are you currently experiencing any complications from your surgery? Yes / No

8. **Have you had an orthopedic total joint (e.g. hip, knee, elbow, finger) replacement?** Yes / No

9. **Have you ever had any radiation therapy or chemotherapy for a growth, tumor or other condition?** Yes / No

10. **In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)?** Yes / No

11. **Do you use or have you used tobacco (smoking, snuff, chew, bidis)?** Yes / No
    a. If yes, please specify amount per day:_____
    b. For how many years ____
    c. If yes, how interested are you in stopping? Very, Somewhat, Not Interested, Smoked in the past (circle)

12. **Do you drink alcoholic beverages?** Yes / No
    a. If yes, how many drinks did you drink in the last 24 hours? _____
    b. If yes, how many drinks do you typically drink in a week?_____
    c. If yes, are you alcohol dependent? Yes / No
    d. If yes, how long have you been alcohol dependent (months)?____
    e. If yes, have you received treatment? Yes / No

13. **Do you use prescription or street drugs or other substances for recreational purposes?** Yes / No
    a. If yes, how often do you use? ___
    b. If yes, are you drug dependent? Yes / No
    c. If yes, how long have you been drug dependent (months)? ___
    d. If yes, have you received treatment? Yes / No

14. **Have you taken, are you taking or are you scheduled to begin taking?**
    a. Oral bisphosphonates: Alendronate (Fosamex, Fosamex Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid)? Yes / No
    b. If yes, what drug, dose and frequency? _____
    c. If yes, what for? _____
    d. If yes, when? _____

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15. **Have you taken, are you taking or are you scheduled to begin taking?**
    a. Intravenous bisphosphonates: Clodronate (Bonefos), Pamidronate (Aredia) or Zolodronic Acid (Reclast, Zometal)? Yes / No
    b. If yes, what drug, dose and frequency? _____
    c. If yes, what for? _____
    d. If yes, when? _____

16. **Women only:**
    a. Are you pregnant? Yes / No
    b. Are you trying to become pregnant? Yes / No
    c. Are you nursing? Yes / No
    d. Are you taking birth control pills, fertility drugs or hormonal replacement? Yes / No

ALLERGIES:
Are you allergic to or have you had a reaction to any of the following?

18. Local anesthetics (or their preservatives) Yes / No
19. Penicillin Yes / No
20. Sulfa drugs Yes / No
21. Other antibiotics Yes / No
22. Codeine or other narcotics Yes / No
23. Aspirin Yes / No
24. Barbiturates (sedatives or sleeping pills) Yes / No
25. Hay fever/seasonal (allergic rhinitis) Yes / No
26. Animals Yes / No
27. Metals/Jewelry (nickel/chrome) Yes / No
28. Food Yes / No
29. Iodine Yes / No
30. Latex (rubber) Yes / No
31. Other/Other Medication(s) Yes / No

If Yes to any of the above, please name: _____Describe reaction_____

MEDICAL CONDITIONS:
Do you have or have you had any of the following diseases, problems, or symptoms?

32. **Cardiovascular/Heart problem** Yes / No (If yes, answer **a** through **t** below)
    a. Rheumatic fever/ heart disease Yes / No
    b. Infective endocarditis Yes / No
    c. Artificial heart valves Yes / No
    d. Congenital heart defect Yes / No
    e. Heart murmur Yes / No
    f. Mitral valve prolapse Yes / No
    g. Angina (chest pain) Yes / No
    h. Heart attack Yes / No
    i. Heart failure Yes / No
    j. Coronary heart disease Yes / No
    k. High blood pressure Yes / No
    l. Low blood pressure Yes / No
    m. Arteriosclerosis Yes / No
    n. Palpitations Yes / No
    o. Arrhythmia (irregular heart beat) Yes / No
    p. Shortness of breath Yes / No
    q. Swelling of the ankles Yes / No
    r. Pacemaker Yes / No
    s. Implantable defibrillator Yes / No
    t. Sleep on two or more pillows Yes / No

33. **Respiratory/Lung problem** Yes / No (If yes, answer **a** through **j** below)
    a. Asthma Yes / No
    b. Emphysema/COPD Yes / No
    c. Tuberculosis Yes / No
    d. Sarcoidosis Yes / No
    e. Pneumonia Yes / No
    f. Sinusitis Yes / No
    g. Bronchitis Yes / No
    h. Persistent cough Yes / No
    i. Sleep apnea Yes / No
    j. Snoring Yes / No

34. **Diabetes/Endocrine disorder** Yes / No (If yes, answer **a** through **c** below)
    a. Diabetes Yes / No
    b. Thyroid problems Yes / No
    c. Adrenal gland disorder Yes / No

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35. **Kidney/Urogenital disorder** Yes / No (If yes, answer **a** through **e** below)
    a. Kidney stones Yes / No
    b. Renal failure/insufficiency Yes / No
    c. Dialysis Yes / No
    d. Prostate Yes / No
    e. Frequent urination Yes / No

36. **Cancer or Tumors** Yes / No (If yes, answer **a** and **b** below)
    a. Malignant Yes / No
    b. Benign Yes / No

37. **Neurologic/Nerve problem** Yes / No (If yes, answer **a** through **q** below)
    a. Stroke Yes / No
    b. TIA (transient ischemic attack) Yes / No
    c. Seizures/epilepsy Yes / No
    d. Multiple sclerosis Yes / No
    e. Parkinson's disease Yes / No
    f. Neuropathies Yes / No
    g. Dementia/Alzheimer's (memory loss) Yes / No
    h. Headache Yes / No
    i. Fainting or dizzy spells Yes / No
    j. Weakness Yes / No
    k. Feeling of tingling or numbness Yes / No
    l. Mental health disorder Yes / No
    m. Post-traumatic stress disorder Yes / No
    n. Obsessive/compulsive disorder
    o. ADD/ADHD (attention deficit disorder) Yes / No
    p. Feelings of anxiety Yes / No
    q. Feelings of depression Yes / No

38. **Blood/Hematologic disorder** Yes / No (If yes, answer **a** through **i** below)
    a. Anemia Yes / No
    b. Thalassemia Yes / No
    c. Sickle cell disease/trait Yes / No
    d. Deep vein thrombosis Yes / No
    e. Bruise easily Yes / No
    f. Leukemia Yes / No
    g. Lymphoma Yes / No
    h. Multiple myeloma Yes / No
    i. Bleeding disorders Yes / No

39. **Gastrointestinal (GI) disorder** Yes / No (If yes, answer **a** through **i** below)
    a. Cirrhosis/chronic hepatitis Yes / No
    b. Jaundice (skin/eyes turn yellow) Yes / No
    c. Hepatitis Yes / No
    d. Heart burn Yes / No
    e. Acid reflux (GERD) Yes / No
    f. Gall stones Yes / No
    g. Ulcers Yes / No
    h. Crohn's disease Yes / No
    i. Irritable bowel syndrome Yes / No

40. **Musculoskeletal/Connective tissue disorder** Yes / No (If yes, answer **a** through **h** below)
    a. Arthritis Yes / No
    b. Osteoporosis Yes / No
    c. Gout Yes / No
    d. Temporomandibular joint disorder Yes / No
    e. Lupus Yes / No
    f. Sclerodema Yes / No
    g. Fibromyalgia Yes / No
    h. Joint replacement Yes / No

41. **Infectious disease** Yes / No (If yes, answer **a** through **f** below)
    a. HIV Yes / No
    b. AIDS Yes / No
    c. Methicillin-resistant Staph aureus (MRSA) Yes / No
    d. STD (sexually transmitted disease) Yes / No
    e. Cold sores Yes / No
    f. Mononucleosis Yes / No

42. **Head/Eye/Ear/Nose/Throat problem** Yes / No (If yes, answer **a** through **e** below)
    a. Vision problems Yes / No
    b. Wear contact lenses Yes / No
    c. Glaucoma Yes / No
    d. Cataract Yes / No
    e. Hearing impairment Yes / No

43. **Dermatologic/Skin problem** Yes / No (If yes, answer **a** and **b** below)
    a. Psoriasis (dry skin) Yes / No
    b. Other_____

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44. **Eating disorder** Yes / No (If yes, answer **a** and **b** below)
    a. Bulimia Yes / No
    b. Anorexia Yes / No

45. **Immunosuppression** Yes / No

46. **Family history of diabetes: If yes, who?__________________**

47. **Family history of heart disease: If yes, who?_________________**

48. **Family history of cancer/tumors: If yes, who?___________________**

49. **Are you concerned about your safety at home?** Yes / No

50. **Do you have any other problem, disease or condition not listed above?** Yes / No
    If yes, please describe:_______________________________________

51. **Are you taking any Anticoagulant or Blood Thinner medication?** Yes / No
    If yes, please describe: ______________________________________

52. **If you are taking, have recently (within the last month) taken, or are supposed to be taking any medications (prescription, over the counter) please specify medication(s), dosage and frequency**

Medication: ___________________________ Medication: ___________________________
Dose: ________________________________ Dose: ________________________________
Frequency: ____________________________ Frequency: ____________________________

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Frequency: ____________________________ Frequency: ____________________________

PATIENT SIGNATURE________________________________ DATE____________________

Revised 2/23/2016