

PRINCETON PARK DENTAL ASSOCIATES, P.A.
CONFIDENTIAL MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Name, address and phone number of your physician: _____

Approximate date of your last physical exam: _____

PLEASE CIRCLE THE ANSWER THAT BEST APPLIES TO YOU

YES NO Are you under the care of a physician for any recent illness or surgery?
If yes, please describe: _____

YES NO Are you taking or have you taken any of the following medications: Fosamax, Actonel,
Bonivia, Aredia, Zometa or any medication containing chemical bisphosphonates?
If yes, please specify: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (including vitamins and herbal supplements)

HAVE YOU HAD ANY OF THE FOLLOWING?

- | | | | |
|--------|---------------------------------------|--------|-------------------------------------|
| Yes No | Rheumatic fever | Yes No | Sleep apnea |
| Yes No | Heart murmur | Yes No | STDs or communicable diseases |
| Yes No | Heart / bypass surgery | Yes No | Psychological or emotional problems |
| Yes No | Mitral valve prolapse | Yes No | HIV positive or AIDS |
| Yes No | Prosthetic (artificial) heart valve | Yes No | Epilepsy, seizures, convulsions |
| Yes No | Cardiac stents | Yes No | Stomach, digestive problems, ulcers |
| Yes No | Organ transplants | Yes No | GERD (reflux) |
| Yes No | Stroke/TIA | Yes No | Thyroid disease |
| Yes No | Pacemaker or defibrillator | Yes No | Autoimmune disorders |
| Yes No | Fainting | Yes No | Fibromyalgia |
| Yes No | Bleeding problems; hemophilia | | |
| Yes No | High blood pressure | | |
| Yes No | Anemia | | |
| Yes No | Asthma, breathing problems, emphysema | | |
| Yes No | Allergies (i.e. Hayfever, etc.) | | |
| Yes No | Hepatitis A B C ____ | | |
| Yes No | Jaundice, liver problems | | |
| Yes No | Renal dialysis, shunt | | |
| Yes No | Sinusitis | | |
| Yes No | Tuberculosis | | |
| Yes No | Kidney or urinary problems | | |
| Yes No | Radiation or X-ray treatment | | |
| Yes No | Chemotherapy, central venous catheter | | |
| Yes No | Cancer or tumors | | |
| Yes No | Arthritis | | |
| Yes No | Artificial joints | | |
| Yes No | Diabetes | | |
| Yes No | Others, please specify _____ | | |

HAVE YOU HAD A BAD REACTION TO:

- Yes No Latex
Yes No Local anesthetics (Novocaine etc.)
Yes No Nitrous oxide
Yes No Oral surgery or tooth extraction
Yes No Penicillin or other antibiotics
Yes No Other drugs or medication
Specify: _____

WOMEN

- Yes No Are you taking birth control pills?
Yes No Are you pregnant?
Yes No Are you menopausal?
Remarks: _____

Any medical problems not listed above? _____

In the event of a medical emergency, whom should we contact? _____

Relationship _____ Phone # _____

Patient's (Parent or Guardian) Signature _____ Date _____