Karl Breuckmann, DDS

MEDICAL HISTORY

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. Thank you for answering the following questions.

Are you under a physician's care now? Yes No; Please Explain:_____
Have you ever been hospitalized or had a major operation? Yes No; Please Explain:_____
_____
Have you ever had a serious head or neck injury? Yes No; Please Explain:_____
Are you taking any medications, vitamins, supplements, pills, or drugs? Yes No; Please List_____
_____
_____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you taking any "Bone Density Medication" (Bisphosphonate)? (e.g. Fosamax, Boniva, Actonel, Didronel, Reclast, etc.) Do you take this medication orally or intravenously? _____
How often do you take this medication? _____
How long have you been taking this medication? _____
Are you taking any type of blood thinner, including aspirin? Yes No
Do you take pre-medication for joint replacement or heart problems? Yes No
Are you on a special diet? Yes No; Explain: _____
Do you use tobacco? Yes No; Type: _____How Often:_____
Do you use controlled substances? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs
Other:
_____
___

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

AIDS/HIV Positive
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain,
_____
_____
_____
Comments:_____
_____

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.

Print Patient Name_____ Date of Birth_____
Signature of Patient, Parent or Guardian:_____Date_____