Time 11:04 AM

Thomas Skoumal D.D.S., P.C.

Date 1/28/2015

Dr. Tom's Medical History (v15.1.25)

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.
Thank you for answering the following questions.

Question	Yes / No	If yes
Are you under a physician's care now? If so, please list their name and phone number.	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Acetaminophen (Tylenol)
- ☐ Acrylic
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metal
- ☐ Penicillin
- ☐ Sulfa Drugs

Other allergy? ☐ If yes

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Do you have, or have you had, any of the following? If you mark "Yes" to any question, please elaborate in the comment section.

Condition	Yes / No
Anemia	○ Yes ○ No
Angina, Chest Pains	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No
Blood Disease/Disorder	○ Yes ○ No
Blood Transfusion	○ Yes ○ No
Bruise Easily	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No
Fainting Spells/Syncope /Dizziness	○ Yes ○ No
Heart Attack/Failure	○ Yes ○ No
Heart Murmur	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No
Heart Stent	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No
Hemophilia	○ Yes ○ No
High Blood Pressure	○ Yes ○ No
High Cholesterol	○ Yes ○ No
Infective Endocarditis	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No
Sickle Cell Disease	○ Yes ○ No
Stroke	○ Yes ○ No
Swelling of Limbs	○ Yes ○ No
Anaphylaxis	○ Yes ○ No
Asthma	○ Yes ○ No
Breathing Problem	○ Yes ○ No
Emphysema	○ Yes ○ No
Frequent Cough	○ Yes ○ No
Hay Fever	○ Yes ○ No
Lung/Respiratory Disease	○ Yes ○ No
Sinus Trouble	○ Yes ○ No
Sleep Disorder	○ Yes ○ No
Snoring	○ Yes ○ No
Digestive Disorders (Celiac/ Gastric Ref	○ Yes ○ No
Somach/Intesinal Disease	○ Yes ○ No
Ulcers	○ Yes ○ No
Frequent Diarrhea	○ Yes ○ No
Diabetes (HbA1c in Comments)	○ Yes ○ No
Glaucoma	○ Yes ○ No
Hormone Deficiency	○ Yes ○ No
Hypoglycemia	○ Yes ○ No
Kidney Problems	○ Yes ○ No
Liver Disease/Jaundice	○ Yes ○ No
Parathyroid Disease	○ Yes ○ No
Renal Dialysis	○ Yes ○ No
Thyroid Disease	○ Yes ○ No
Cancer/Tumors/Growths	○ Yes ○ No
Chemotherapy /Immunosuppression	○ Yes ○ No
Radiation Treatments	○ Yes ○ No
Recent Weight Loss	○ Yes ○ No
Arthritis/Gout/Lupus	○ Yes ○ No
Artificial Joint	○ Yes ○ No
Cortisone Medicine	○ Yes ○ No
Head or Neck Injury	○ Yes ○ No
Osteoporosis/Osteopenia	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No
Rheumatism	○ Yes ○ No
AIDS/HIV	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No
Hepatitis (Specify Type in Comments)	○ Yes ○ No
Herpes	○ Yes ○ No
Hives/Rash	○ Yes ○ No
Rheumatic/Scarlet Fever	○ Yes ○ No
Shingles	○ Yes ○ No
STD	○ Yes ○ No
Tonsillitis	○ Yes ○ No
Tuberculosis	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No
Drug Addiction	○ Yes ○ No
Epilepsy/Seizures /Convulsions	○ Yes ○ No
Frequent Headaches	○ Yes ○ No
Mental Handicap	○ Yes ○ No
Neurologic Condition (ADD/Depressio/MS)	○ Yes ○ No
Psychiatric Care	○ Yes ○ No
Anxiety (Dental or Other)	○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments and Additional Information (use back of page if needed):

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:___________