Barrero Dental Boutique

Welcome! So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health

MEDICAL HISTORY

Name: _____ Birth date_____ Gender _____

Premed _____ BP _____ Date of last physical _____

Name and number of Physician _____

Please describe any major illness or hospitalizations in the last year.

Please list any medications/ drugs/pills you are currently taking.

Please check if you are allergic (or have had adverse reactions) to:

☐ Latex ☐ Codeine ☐ Local Anesthetic ☐ Sulfa ☐ Other antibiotics ☐ Other
☐ Aspirin ☐ None ☐ Penicillin

In case of an emergency, are there any special instructions you would like us to know?

Please check if you have, or have ever had any of the following:

Respiratory:

☐ Sinus Problems ☐ Asthma ☐ Allergies/Hives ☐ Tuberculosis (TB) ☐ Emphysema/Bronchitis

Cardiovascular:

☐ Heart Disease ☐ Heart attack or failure ☐ Angina ☐ High Cholesterol
☐ Stroke ☐ Mitral Valve Prolapse ☐ Aneurysm ☐ Heart Problems at Birth
☐ Heart Murmur ☐ High Blood Pressure ☐ Pacemaker/Defibrillator
☐ Damaged/Artificial Heart Valves ☐ Arrhythmias/Palpitations
☐ Rheumatic Fever/ Rheumatic Heart disease ☐ Heart Surgery/Transplant

Hematologic:

☐ Blood Transfusion ☐ Sickle Cell/ Abnormal Bleeding ☐ Anemia ☐ Leukemia ☐ Hemophilia

Urogenital:

☐ Hepatitis Type_____ ☐ Kidney/ Bladder Problem ☐ Sexually Transmitted Disease
☐ HIV/AIDS

Endocrine: ☐ Diabetes ☐ Thyroid Disease

Gastrointestinal:
☐ Stomach/Intestinal Ulcers ☐ Colitis ☐ Liver Disease ☐ GERD/Reflux ☐ Gastritis

Dermal/Muscular/Skeletal:
☐ Arthritis ☐ Skin Rash/ Disease ☐ Dark Moles ☐ Artificial Joint
☐ Discolored Areas in Mouth

Neural/Sensory:
☐ Severe/ Frequent Headaches ☐ Depression ☐ Glaucoma ☐ Contact lenses
☐ Nervousness/Phobias/Anxiety ☐ Dementia ☐ Fibromyalgia ☐ Fainting/ Dizziness
☐ Epilepsy/Seizures/Convulsions ☐ Psychiatric Treatment

Other Conditions:
☐ Tumor/Cancer ☐ X-Ray Treatment to Head/Neck ☐ Chemotherapy
☐ Sleep Apnea ☐ Hearing Problems

WOMEN: ☐ Are you Pregnant? ☐ Breast feeding? ☐ Taking Birth Control Medication?

If you use (or have used) any of the following, please describe:

Tobacco Product (type, frequency, amount, how long?)

Are you currently, or have you ever been in recovery for drug/ alcohol addiction? ____ Yes
Alcohol (frequency, amount, how long?)

Is there any other information regarding MEDICATIONS, DRUGS, OR HEALTH CONDITIONS WE SHOULD KNOW?

Doctor's Comments:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify my dentist of any changes in my health or medication.

Signature of Patient or Patient's Guardian Date