

## Medical History for All patients of *Jose A. Sapia, D.M.D., P.C.*

\*\*\*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.

Who is your primary care Doctor? \_\_\_\_\_

Have you had major surgery or been hospitalized in the last 5 years? \_\_\_\_\_

Have you had a serious head or neck injury? \_\_\_\_\_

Are you taking any medications, vitamins or aspirin? Please List ALL: \_\_\_\_\_

Are you on a special diet? Please elaborate: \_\_\_\_\_

Do you smoke or chew tobacco? \_\_\_\_\_

**Women:** Are you

Pregnant?

Nursing?

Taking Oral Contraceptives?

**Allergies:**

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa

Local Anesthetics

Please list any other allergies not listed: \_\_\_\_\_

Do you have or have you had any of the following? Please check all that apply:

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

Please List any serious illness or condition you have had not listed: \_\_\_\_\_

\*All questions on this form have been answered accurately and it is my responsibility to update my medical status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_