DAVID R. LEONOFF, DDS, PC

Patient Medical History Form

Date: _____

Name_____

Address_____

City_____State_____Zip_____

Sex M/F____

Date of Birth_____

Emergency Contact Info: Name_____ Phone #_____

Please answer all of the following questions (circle YES or NO if asked):

1. Do you need to pre-medicate with antibiotics for your dental appointments?
   This is usually people with heart conditions or joint replacements……Yes No
2. Are you currently under the care of a physician?……..……Yes No
3. Name and address of your physician_____
   _____
4. What medical condition(s) are being treated?
   _____
5. Have you recently had any serious illness or hospitalization? ……..Yes No
6. If so, what was the illness/reason?
   _____
7. Are you currently taking any medication(s)? ……..…….Yes No
8. If so, what medications are you taking (prescribed or not)? (You can attach a list if needed):

_____
_____
_____
_____

Pharmacy Information: _____

Please turn over…

Does your medical history include any of the following:

9. Rheumatic or congenital (inborn) heart disease?……..Yes No
10. Heart murmur, damaged or artificial heart valves?……..Yes No
11. Cardiovascular disease (heart trouble)?……Yes No
12. High or low blood pressure? (Circle high or low if applicable)……Yes No
13. Do you have a cardiac pacemaker?……..……Yes No
14. Asthma, emphysema, or pulmonary disorders?……..Yes No
15. Fainting, seizures, epilepsy, or neurological disorders?……Yes No
16. Diabetes?……..……Yes No
17. Hepatitis, jaundice, or other liver disease?……..……..Yes No
18. Sexually transmitted disease?……..……..Yes No
19. Aids or HIV infections?……..……Yes No
20. Thyroid problems?……Yes No
21. Stomach ulcer?……..……Yes No
22. Kidney trouble?……..……Yes No
23. Problems with mental health?……Yes No
24. Cancer or treatment for tumor or growth?……Yes No
25. Problems of the immune system?……..…Yes No
26. Osteoporosis or osteopenia?……..……..Yes No
27. Blood disorders, such as anemia?……..Yes No
28. Abnormal bleeding?……..……Yes No
29. Have you ever required a blood transfusion?……..…Yes No
30. Do you have glaucoma or eye disorders?……..……..Yes No
31. Have you had joint replacement surgery (knee, hip, etc.)?……..…Yes No

Are you allergic or have you ever had any reaction to:

32. Local anesthetics (novocaine)……Yes No
33. Penicillin?……..……Yes No
34. Sulfa drugs or other antibiotics?……..……Yes No
35. Barbiturates, sedatives, or sleeping pills?……..……..Yes No
36. Aspirin, acetaminophen (tylenol), or Advil (ibuprofen)……Yes No
37. Codeine or other narcotics?……..……Yes No
38. Any other drugs or medications?……..……..…Yes No

For Female Patients:

39. Are you pregnant?……..……..Yes No
40. Are you nursing?……..……Yes No
41. Are you taking birth control pills?……..…..Yes No

The medical information I have provided is correct.

_____ _____

Patient Signature (parent's signature if pt. is a minor) Date