Dentistry By Dr. Genoveva Caminschi

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Medical History Update

Please answer the following questions to the best of your knowledge.

Name:_____ Date:_____

1. Are you being treated for any medical condition presently or have you been treated within the past year? ☐Yes ☐No
   If yes, why?
   _____
2. When was your last medical check up?_____
3. Has there been any change in your general health in the past year? ☐Yes ☐No
   If yes, please explain
   _____
4. Are you taking any medications, non-prescription drugs or herbal supplements? ☐Yes ☐No
   If yes, please list
   _____
5. Do you have any allergies? ☐Yes ☐No
   If yes, please list using the categories below:
   a) Medications _____
   b) latex/rubber products _____
   c) other (i.e. hayfever, foods) _____
6. Have you ever had a peculiar or adverse reaction to any medications or injections? ☐Yes ☐No
   If yes, please explain
   _____
7. Do you have or have you ever had asthma? ☐Yes ☐No
8. Do you have or have you ever had any heart or blood pressure problems? ☐Yes ☐No
9. Do you have or have you ever had an artificial heart valve, an infection to the heart, a heart condition from birth, or a heart transplant? ☐Yes ☐No
10. Do you have a prosthetic or artificial joint? ☐Yes ☐No
11. Do you have any conditions or therapies that could affect your immune system (i.e. leukemia, AIDS, HIV, radiotherapy, chemotherapy)? ☐Yes ☐No
12. Have you ever had hepatitis, jaundice, or liver disease? ☐Yes ☐No
13. Do you have a bleeding problem, or bleeding disorder? ☐Yes ☐No
14. Have you ever been hospitalized for any illness or operation? ☐Yes ☐No
    If yes, please explain
    _____
15. Are there any conditions or medical problems that run in your family? ☐Yes ☐No
16. Do you smoke or chew tobacco products? ☐Yes ☐No
17. Are you nervouse during dental treatment? ☐Yes ☐No

21. Do you have or have you ever had any of the following:

Chest pain, angina	☐	Diabetes	☐	Lung Disease	☐
Heart attack	☐	Stomach Ulcers	☐	Tuberculosis	☐
Stroke	☐	Arthritis	☐	Cancer	☐
Shortness of breath	☐	Seizures (epilepsy)	☐	Steroid therapy	☐
Rheumatic fever	☐	Kidney disease	☐		
Mitral valve prolapse	☐	Thyroid disease	☐		
Heart murmur	☐	Drug/alcohol dependency	☐		
Pacemaker	☐	Osteoporosis medication	☐		

18. **FOR WOMEN ONLY:** Are you breastfeeding or pregnant? ☐ Yes ☐ No
19. If pregnant, what is the expected due date?
20. _____

DISCLAIMER

I certify that I have provided an accurate and complete medical history for myself (or my dependent) and have not omitted any information. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform Dr. Caminschi and/or her staff of any changes in my medical status. I authorize Dr. Caminschi and her team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient/Parent/Guardian Signature Date

Dentist Signature Date