STOMATOLOGIA
NA PODZAMCZU

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MEDICAL HISTORY

PLEASE INFORM US IN THE FUTURE OF ANY CHANGE IN HEALTH HISTORY AND MEDICATIONS TAKEN

Name _____ Age _____

Overall health rating:

☐ Excellent ☐ Good ☐ Not bad ☐ Poor

Last general examination _____ Reason _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD	YES	NO
1. Hospital treatment due to illness/injury (Which / what?) _____	☐	☐
2. Adverse reaction to:	☐	☐
☐ aspirin, ibuprofen, paracetamol, codeine		
☐ penicillin ☐ erythromycin ☐ tetracycline		
☐ sulfonamides		
☐ local anesthetics		
☐ fluoride		
☐ metals (nickel, gold, silver, others)		
☐ rubber		
☐ other (what kind?) _____		
3. Heart problem or cardiac stent (last 6 months)	☐	☐
4. History of infective endocarditis	☐	☐
5. Artificial heart valve or corrected heart defect (PFO)	☐	☐
6. Pacemaker or implantable defibrillator	☐	☐
7. Artificial prosthesis (heart or joint valve)	☐	☐
8. Acute arthritis or scarlet fever	☐	☐
9a. High pressure	☐	☐
9b. Low blood pressure	☐	☐
10. Stroke / you are taking blood-thinning drugs)	☐	☐
11. Anemia or other blood disorders	☐	☐
12. Prolonged bleeding due to a minor cut (INR>3.5)	☐	☐
13. Emphysema, sarcoidosis	☐	☐
14. Tuberculosis	☐	☐
15. Asthma	☐	☐
16. Breathing or sleep problems (e.g., snoring, sinus problems)	☐	☐
17. Kidney disease	☐	☐
18. Liver disease	☐	☐
19. Jaundice	☐	☐
20. Parathyroid gland disease or calcium deficiency	☐	☐
21. Hormone deficiency	☐	☐
22. High cholesterol or taking a statin	☐	☐
23. Diabetes Type I	☐	☐
Type II	☐	☐

	YES	NO
24. Gastric or duodenal ulcer	☐	☐
25. Digestive disorders (e.g., gastric reflux)	☐	☐
26. Osteoporosis/osteopenia (e.g., taking Bisphosphonates)	☐	☐
27. Arthritis (arthritis)	☐	☐
28. Glaucoma	☐	☐
29. Contact lenses	☐	☐
30. Head or neck injuries	☐	☐
31. Epilepsy, epileptic seizures (epilepsy)	☐	☐
32. Neurological problems (attention deficit disorder)	☐	☐
33. Viral infections and herpes	☐	☐
34. Any swelling or lumps in the mouth	☐	☐
35. Hives, skin rash, hay fever	☐	☐
36. Venereal diseases	☐	☐
37. Hepatitis (type .....)	☐	☐
38. HIV/ AIDS	☐	☐
39. Tumor, abnormal growth	☐	☐
40. Treatment with radiation	☐	☐
41. Chemotherapy	☐	☐
42. Emotional problems	☐	☐
43. Psychiatric treatment	☐	☐
44. Antidepressant medications	☐	☐
45. Alcohol or drug addiction	☐	☐
PLEASE ANSWER IF:		
46. You are currently being treated for any other diseases	☐	☐
47. You see a change in your overall health	☐	☐
48. You take medication to maintain your weight	☐	☐
49. You take dietary supplements	☐	☐
50. You often feel exhausted or fatigued	☐	☐
51. You are prone to frequent headaches	☐	☐
52. You smoke cigarettes or have smoked in the past	☐	☐
53. You are considered an irritable person	☐	☐
54. You are often unhappy or get depressed	☐	☐
55. You are taking contraceptives (FEMALE)	☐	☐
56. You are pregnant (WOMAN)	☐	☐
57. You have a prostate disorder (MALE)	☐	☐

Describe your current or any other treatment, or any upcoming surgeries that may affect your dental treatment.
Provide a list of any medications, supplements, or vitamins you have taken in the past two years.
Ask for an extra sheet of paper if the list of these medications goes beyond 6 items.

Drug _____ Reason _____ Drug _____ Reason _____
Drug _____ Reason _____ Drug _____ Reason _____
Drug _____ Reason _____ Drug _____ Reason _____

I agree to have dental procedures performed on me under local, superficial, infiltration and wire anesthesia, with violation of tissue continuity, with the use of a needle.

Date / Signature of patient _____ Date / Signature of doctor _____