James M. Cooper D.D.S.

MEDICAL HISTORY- Adult

Date_____

Patient Name_____ Preferred Name_____

Date of Birth_____ Social Security #_____

Address_____City_____Zip: _____

Please circle : Single Married Divorced Widowed Male Female

Home Phone_____ May We Leave A Message **YES** **NO**

Cell _____ May We Text You **YES** **NO**

Email_____ May We Email You **YES** **NO**

How would you like us to confirm your appointment _____

Primary Physician _____ Phone _____

Pharmacy Name and Number_____

DO YOU HAVE ANY OF THE FOLLOWING? THIS INFORMATION IS REQUIRED SO THAT WE MAY PROVIDE THE SAFEST AND APPROPRIATE TREATMENT FOR OUR PATIENTS.

___ High or low blood pressure
___ Medication for BP **YES** **NO**
___ Heart murmur, mitral valve prolapse
___ Artificial heart valve or damaged valves
___ Heart ailment or angina
___ Bypass surgery
___ Coronary stents
___ Cardiac pacemaker or defibrillator
___ Abnormal heart rhythm
___ Blood thinners/Medication_____
___ Artificial joints Date _____
___ Stroke
___ Blood disorder or bleeding problems
___ Hepatitis A, B or C
___ Liver disease
___ Kidney disease
___ Tuberculosis
___ Emphysema
___ Chronic bronchitis
___ Asthma
___ COPD
___ Tobacco use
___ Diabetes Type **1** **2**
___ Arthritis
___ Hearing impairment
___ Behavioral/Learning Disorder
___ Hay fever or sinus problems
___ Dementia
___ Dry mouth
___ Cancer
___ Radiation / Chemo
___ Thyroid disorder
___ Epilepsy, seizures, or fainting spells
___ Herpes or cold sores
___ AIDS / HIV Positive
___ Gastrointestinal problems
___ Eye or ear problems
___ Migraine or frequent headaches
___ Pregnant, nursing or birth control
___ Dizziness
___ Frequent yeast or candida Infection
___ Allergies or Reaction to Medication
Epinephrine_____
Sulfa_____
Penicillin_____
Latex_____
Anesthetics_____
Other _____

Name: _____ **Date of Birth:** _____

1. Have you been hospitalized or had surgery within the past 5 years? **YES** **NO**

   Please explain: _____

2. Are you under the care of a physician for any current health issues?

   Please explain: _____

   _____

3. Have you had excessive bleeding or trouble following dental treatment? **YES** **NO**
4. Do you require Antibiotics before dental treatment? **YES** **NO**

   Reason: _____

5. Have you recently traveled out of the country? **YES** **NO**

   If so, where: _____

6. List ALL drugs or medications that you're currently taking…including prescription / non-prescription medications, aspirin, birth control pills, herbal treatments and vitamins.

Prescribed Current Medications	**Over the Counter Medications**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any dental concerns or anything you would like to address with the dentist or hygienist?

_____

_____

I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE **DATE**

Reviewed by:_____ Date _____ Reviewed by:_____ Date _____
Reviewed by:_____ Date _____ Reviewed by:_____ Date _____
Reviewed by:_____ Date _____ Reviewed by:_____ Date _____