Andrew G. Gilfillan, D.D.S.

MEDICAL HISTORY

Name_____ Date of Birth_____ Today's Date_____

Name of physician_____ Phone Number_____

Have you seen a physician for a medical condition in the last six months? □ Yes □ No

If so when and why?_____

Have you had an operation, illness or been hospitalized in the last five years? □ Yes □ No

If so when and why?_____

Have you ever had oral or I.V. bisphosphonate therapy? □ Yes □ No

(Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos)

If so when and how long did you have this treatment?_____

Have you ever been instructed to pre-medicate with antibiotics prior to dental treatment for any health related condition such as a Heart Murmur, Artificial Joints, Rheumatic Fever etc.? □ Yes □ No

Please list all prescription and over the counter medications you are taking:

Allergies:	Y	N
Aspirin	□	□
Codeine	□	□
Dental Anesthetics	□	□
Erythromycin	□	□
Jewelry	□	□
Latex	□	□
Metals	□	□
Penicillin	□	□
Tetracycline	□	□

Other_____

Women: Are you pregnant □ Yes □ No If yes, # of weeks _____

Are you nursing □ Yes □ No

Are you taking birth control □ Yes □ No

Cardio vascular

- ❑ High Blood Pressure
- ❑ Heart Attack
  If so when_____
- ❑ Angina / Chest Pain
  If so when_____
- ❑ Damaged Heart Valves
  Describe_____
- ❑ Heart Murmur
- ❑ Mitral Valve Prolapse
- ❑ Rheumatic Fever
- ❑ Congenital Heart Defect
- ❑ Irregular Heartbeat
- ❑ Pacemaker
- ❑ Heart Surgery
  If so when?_____
- ❑ Other Heart Problems
  Describe_____

Skin/Musculoskeletal

- ❑ Arthritis
- ❑ Back or Neck problem
- ❑ Artificial Joint
  If so when_____
  What joint_____

Nerves & Sensory

- ❑ Epilepsy / Seizures
- ❑ Fainting / Dizziness
- ❑ Nervousness
- ❑ Numbness or Tingling

Respiratory

- ❑ Bronchitis / Chronic Cough
- ❑ Sinus Problems
- ❑ Tuberculosis (TB)
- ❑ Asthma
  Use inhaler?_____
  How often_____

Endocrine

- ❑ Diabetes
  Take insulin?_____
- ❑ Thyroid Disease

Hematologic

- ❑ Anemia
- ❑ Prolonged Bleeding
- ❑ Take Blood Thinners
- ❑ HIV / AIDS positive
- ❑ Stroke
  If so when_____

Gastrointestinal

- ❑ Gastric Reflux
- ❑ Gastric Bypass Surgery
- ❑ Stomach Ulcers
- ❑ Liver Disease
- ❑ Hepatitis
  Type_____
  When_____

Urinary

- ❑ Kidney Problems

Other Conditions

- ❑ Mental Health Problems
- ❑ Eye Disease / Tumors
- ❑ Alcohol Abuse
- ❑ Drug Abuse
- ❑ Excessive Snoring
- ❑ Cortisone Treatment
- ❑ Cancer / Tumors
  Type_____
- ❑ Radiation / Chemotherapy
  Where_____
  When_____
- ❑ Use Tobacco
  Type_____
  How much_____

Please list any other medical conditions or concerns not mentioned above that the doctor should be aware of:_____

Do you wish to speak to the doctor privately about anything?_____

Please Complete Dental History Form on Next Page