PETER J KAUFMAN D.M.D. PA.

MEDICAL HISTORY FORM

Name: _____ Age: _____ Date of Birth: _____

Dentist: _____ Physician: _____

Are you now or have you been under the care of a physician during the past five years? Reason: ❑Yes ❑No

_____

Have you ever had general anesthesia? If yes, when and for what reason? Any complications? ❑Yes ❑No

_____

Please list all your medications and doses? (Additional page behind or provide us a list to photocopy)

_____

_____

Do you pre-med? If yes, for what condition? _____ ❑Yes ❑No

Are you allergic to any medications? Please list medication and reaction: ❑Yes ❑No

_____

Do you take blood thinners, or have you ever had any excessive bleeding requiring special treatment? ❑Yes ❑No

Have you ever taken Cortisone or Steroids? If yes, when: _____ ❑Yes ❑No

Do you now have a cough or cold? ❑Yes ❑No

Number of cigarettes you smoke in a day and number of years you have smoked: _____ ❑Yes ❑No

Are you now or have you ever taken any bisphosphonates (bone strengthening medications)? ❑Yes ❑No

Please List: _____

Have you ever had any radiation to the head and neck area? ❑Yes ❑No

If female, are you now pregnant or nursing? ❑Yes ❑No

If female, do you take birth control pills (OCP)? ❑Yes ❑No

*If antibiotics are prescribed they may decrease the effectiveness of your OCP requiring additional contraceptive methods to prevent pregnancy.

Check any of the following of which you are being treated for or have had in the past:

❑ High Blood Pressure	❑ Tuberculosis	❑ Diabetes
❑ Heart Trouble	❑ Bronchitis	❑ Hepatitis/Liver disease
❑ Heart Murmur	❑ Emphysema	❑ Osteoporosis
❑ Rheumatic Fever	❑ Asthma	❑ HIV
❑ Angina/Chest Pain	❑ Shortness of Breath	❑ Stroke
❑ Artificial Heart Valve	❑ Anemia	❑ Seizures
❑ Heart Pacemaker	❑ Blood Disorder	❑ Fainting Spells
❑ Heart Surgery	❑ Ulcers	❑ Kidney Trouble
❑ Congenital Heart Lesion	❑ Arthritis	❑ Thyroid Disease
❑ Artificial Joint	❑ Nervousness	❑ Radiation Therapy
❑ Glaucoma	❑ Psychiatric Treatment	❑ Chemotherapy

The above health history is accurate to the best of my knowledge.

_____ _____

Signature Date

Medication List:

PLEASE LIST ALL CURRENT MEDICATIONS

Additional health history notes: