FORT WAYNE SMILES, PC
Dr. David Reichwage

MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: _____ Sex: M ☐ / F ☐

For the following questions check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? Y ☐ N ☐
2. Has there been any change in your health in the past year? Y ☐ N ☐
3. My last physical exam was on _____
4. Are you now under the care of a physician? Y ☐ N ☐
   If so for what condition? _____
5. Name of Physician _____
   Address _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? Y ☐ N ☐
7. Are you taking medicine(s) including non-prescription, homeopathic, or "natural" remedies including diet pills? Y ☐ N ☐
   If so please list _____
8. Do you require pre-medication with antibiotics prior to dental appointments? Y ☐ N ☐
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves, heart murmur Y ☐ N ☐
   b. Rheumatic Fever Y ☐ N ☐
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, or any other heart condition Y ☐ N ☐
      1. Chest pain upon exertion? Y ☐ N ☐
      2. Shortness of breath after mild exercise? Y ☐ N ☐
      3. Do your ankles swell? Y ☐ N ☐
      4. Do you have a pacemaker? Y ☐ N ☐
      5. Do you have any pins/plates, artificial joints, or shunts placed? Y ☐ N ☐
         If yes when? _____
         Physician: _____
         Phone: _____
   d. Seasonal allergies/ Hives Y ☐ N ☐
   e. Sinus trouble Y ☐ N ☐
   f. Asthma or hay fever Y ☐ N ☐
   g. Fainting spells or seizures Y ☐ N ☐
   h. Diabetes Y ☐ N ☐
   i. Hepatitis, jaundice or liver disease Y ☐ N ☐
   j. Frequent or recurring mouth sores Y ☐ N ☐
   k. Thyroid problems Y ☐ N ☐
   l. Respiratory problems, emphysema, bronchitis, etc Y ☐ N ☐
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) Y ☐ N ☐
   n. Stomach ulcer or hyperacidity Y ☐ N ☐
   o. Kidney trouble Y ☐ N ☐
   p. Tuberculosis Y ☐ N ☐
   q. Persistent cough or cough that produces blood Y ☐ N ☐
   r. Persistent swollen neck glands Y ☐ N ☐
   s. Low blood pressure or high blood pressure Y ☐ N ☐
   t. Epilepsy or neurological disorder Y ☐ N ☐
   u. Cancer Y ☐ N ☐
   v. Any disease, drug or transplant operation that has depressed your immune system Y ☐ N ☐
10. Have you had abnormal bleeding? Y ☐ N ☐
    a. Have you ever required a blood transfusion? Y ☐ N ☐
11. Do you have any blood disorder such as anemia? Y ☐ N ☐
12. Have you ever had treatment for a tumor or growth? Y ☐ N ☐
    If yes, what type of treatment _____
13. Are you allergic to or have you had a reaction to:
    a. Local anesthetics Y ☐ N ☐
    b. Penicillin or antibiotics Y ☐ N ☐
    c. Sulfa drugs or sulfide Y ☐ N ☐
    d. Barbiturates or sleeping pills Y ☐ N ☐
    e. Aspirin Y ☐ N ☐
    f. Iodine Y ☐ N ☐
    g. Codeine or other narcotics Y ☐ N ☐
    h. Latex or rubber products Y ☐ N ☐
    i. Other Y ☐ N ☐
    If Yes please describe your symptoms/ reaction _____
14. Have you had any serious trouble associated with previous dental treatment? Y ☐ N ☐
15. Do you have any other condition or disease you think the doctor should know about? Y ☐ N ☐
16. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis, chemotherapy or multiple myeloma, etc.)? Y ☐ N ☐
17. Are you wearing contact lenses? Y ☐ N ☐
18. Are you wearing removable dental appliances? Y ☐ N ☐
19. Do you wish to talk with the doctor privately about anything? Y ☐ N ☐
20. Do you smoke? Have you smoked or chewed tobacco? Y ☐ N ☐
21. Have you had treatment for drug or alcohol abuse? Y ☐ N ☐
22. Do you have or have you had any of the following symptoms:
    a. Headaches or migraines Y ☐ N ☐
    b. Facial pain Y ☐ N ☐
    c. Neck/ shoulder pain Y ☐ N ☐
    d. Tinnitus/ Ringing in the ears Y ☐ N ☐
    e. Worn or cracked teeth Y ☐ N ☐
    f. Unexplained loose teeth Y ☐ N ☐
    g. Sensitive or sore teeth Y ☐ N ☐
    h. Jaw Pain Y ☐ N ☐
    i. Numbness in fingers or arm Y ☐ N ☐
    j. Clicking or popping in the jaw joints Y ☐ N ☐
    k. Limited jaw movement or locking jaw Y ☐ N ☐

WOMEN:

23. Are you pregnant or trying to become pregnant? Y ☐ N ☐
24. Are you nursing? Y ☐ N ☐
25. Are you taking birth control pills? Y ☐ N ☐

Fully Explain any answered "Yes" above _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

Date: _____ Patients Signature _____