GERMAN VILLAGE
DENTAL GROUP
NICOLE K. MUNZ, D.D.S., INC.
GENERAL DENTISTRY

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MEDICAL AND DENTAL HISTORY
FOR

_____

1. How would you rate your overall health? GOOD FAIR POOR

2. Date of your last physical examination?_____

3. Are you currently under the care of a physician? YES NO

4. Physician information:
   Name:_____
   Phone #:_____
   Address:_____

5. Have you had any serious illness, operations, or been hospitalized within the past 5 years?
   YES NO

6. Have you had any cosmetic procedures or elective surgeries completed?
   YES NO
   If yes, please describe:_____

7. Have you had medical x-rays in the last 5 years: YES NO
   If yes, please describe:_____

8. Are you taking any prescription medications, over-the-counter medications, creams, supplements or herbs?
   YES NO
   If yes, please list all:

	NAME	DOSE/FREQUENCY	REASON FOR TAKING
PRESCRIBED MEDICATIONS			
OVER-THE-COUNTER MEDICATIONS			
VITAMINS, NATURAL OR HERBAL PREPARATIONS, DIET SUPPLEMNETS			

continue to next page...

NAME:_____

9. Do you use tobacco products? YES NO

10. Do you drink alcoholic beverages? YES NO

11. Do you use recreational or street drugs? YES NO

12. Do you have any ALLERGIES (i.e. itching, rash, swelling of hands, eyes or feet), or are you made sick by metals, jewelry, latex rubber, apirin, penicillin, codeine or any other drugs, foods, or medications?
YES NO

If yes, please list what you are allergic to and your reaction:_____

_____

_____

13. When you walk up stairs or take a walk, do you ever have to stop because of chest pain?
YES NO

14. Do your ankles swell during the day? YES NO

15. Do you use more than two pillows to sleep? YES NO

16. Do you wake up short of breath? YES NO

17. Have you lost or gained more than 10 pounds in the last year? YES NO

18. Are you on a special diet? YES NO

19. Have you ever been told that you needed to be premedicated prior to any dental work?
YES NO

If yes, for what reason?_____

Check any of the following *cardiovascular/heart* conditions you currently have or have had in the past:

_Angina
_Chest pain upon exertion
_Coronary artery disease
_Heart murmur
_Irregular heart beat
_Heart pacemaker
_Scarlet fever
_NONE
_Arteriosclerosis
_Congenital heart lesions/defects
_Damaged heart valves
_Heart surgery
_Low blood pressure
_Rheumatic heart disease/Rheumatic fever
_Stroke
_Artificial heart valves
_Congestive heart failure
_Heart attack
_High blood pressure
_Mitral valve prolapse
_Other: _____

Check any of the following *respiratory* conditions you currently have or have had in the past:

_Asthma
_Hay fever
_Sinus problems
_NONE
_Bronchitis
_Persistent cough or cough that produces blood
_Tuberculosis(TB)
_Emphysema
_Shortness of breath
_Other:_____

continue to next page...

NAME:_____

Check any of the following ***blood*** disorders you currently have or have had in the past:

_Abnormal bleeding
_Anemia
_Blood transfusion
_Bruise easily
_Hemophilia
_Excessive bleeding
_Leukemia
_Sickle cell disease
_Other:_____
_NONE

Check any of the following ***psychological*** conditions you currently have or have had in the past:

_Anxiety
_Depression
_Psychiatric treatment
_Nervousness
_Other:_____
_NONE

Check any of the following ***liver*** conditions you currently have or have had in the past:

_Cirrhosis/liver disease
_Hepatitis
_Jaundice/yellow jaundice
_Other:_____
_NONE

Check any of the following ***health*** conditions you currently have or have had in the past:

_Allergies or hives
_Arthritis
_Artificial joint
_Cancer
_Chemotherapy
_Cold sores/fever blisters
_Cortisone medication
_Drug addiction
_Epilepsy or seizures
_Diabetes(type 1 or type 2)
_Fainting or dizzy spells
_Glaucoma
_Herpes
_HIV antibody or AIDS
_Irritable bowel
_Ulcers
_Measles
_Mumps
_Radiation treatment
_Rheumatism
_Tumor
_Sexually transmitted disese
_Stomach problems
_Thyroid disease
_Mononucleosis
_kidney disease/dialysis
_NONE

Do you have any disease, condition, or problem that was not previously listed?
YES NO

If yes, please describe here:_____

FOR WOMEN:

1. Are you pregnant? YES NO
2. Are you looking to become pregnant? YES NO
3. Are you nursing? YES NO

Please read and initial:
I understand it is my responsibility to inform the office if I am pregnant, looking to become pregnant or nursing since it will affect my dental care and the scheduling of appointments._____

4. Are you using a contraceptive? YES NO
If yes, please read and initial.
I understand that taking antibiotics may render contraceptives ineffective._____

To the best of my knowledge, all of the proceding health history answers are true and correct. I also understand that it is my responsibilty to inform the office of any changes to my medical history prior to all appointments.

PATIENT/GUARDIAN_____ DATE_____

REVIEWED BY:_____ DATE_____