Galdos Dental Medical History

Patient Name (PRINT) _____

Date of Birth_____ Age_____ Weight_____(lbs) Height_____

1. Have you been hospitalized or under the care of a **medical doctor** during the past two years? Reason?

   _____

2. **List medications** taken the past two years and reason:

   _____

   _____

3. List **allergy** (i.e., itching, rash, swelling, vomiting) to latex, penicillin, aspirin, or any other medication:

   _____

4. **CIRCLE** any of the following you have or have had:

Heart Attack/Disease	Inherited Condition/Birth Defect	Rash/Hives/Eczema/Skin Problem
Heart Failure/CHF	Sickle Cell Disease	Glaucoma
Heart Surgery/Stent	Anemia/Blood disorder	Impaired Hearing/Vision/Speech
Angina Pectoris (Chest Pain)	High/Low Blood Pressure	Psychiatric Treatment
Heart Murmur	Transfusion/Receiving Blood Product	Nervous/Anxiety Disorder
Congenital Heart Defect	Diabetes Type 1 / 2	Fainting/Dizzy Spells
Pacemaker	Hyper/Hypoglycemia	Sinus Problems/Infections
Artificial Heart Valve	MRSA (methicillin resistant staph)	Epilepsy/Seizures
Bacterial Endocarditis	Hemophilia	Steroid Therapy
Stroke/Aneurysm	Gastroesophageal Reflux	Current or Previous Tobacco Use
Rheumatic Fever	Stomach Ulcers	Sexually Transmitted Disease
Tuberculosis (TB)	Organ Transplant	AIDS Related/HIV
Sarcoidosis	Artificial Joint	Alcoholism
Emphysema	Tumor	Recreational Drug Use/Addiction
Asthma/Airway Disease	Cancer Type: _____	Vaping
Hepatitis/Jaundice/Liver Disease	Chemotherapy/Radiation	Allergies – Food, Metal, Etc.
Thyroid/Pituitary Disease	Arthritis/Scoliosis/Joint Problem	Cankers/Cold Sores/Apthous Ulcer
Cystic Fibrosis	Bladder/Kidney Disease	Eating Disorder/Special Diet
Chronic Obstructive Pulmonary Disorder		Sexual Enhancement Drugs (ie. Viagra)

5. Ever been victim of **abuse** or neglect (physical, emotional, psychological, sexual)? _____
6. Ever had a reaction to or problem with an **anesthetic**? _____
7. Can you **walk a flight of stairs** without exhaustion or needing a break? Yes or No?
8. Any significant medical history not listed above that the **dentist** should be told?

   _____

9. **Women:** Pregnant? Yes or No? Is there a possibility you are pregnant? Yes or No?
   Nursing? Yes or No? Birth Control? Yes or No?

To the best of my knowledge all of the preceding answers are true and correct. I will notify my provider at next visit if there has been any change.

_____ _____

Date Signature of Patient or Guardian

Signature of Doctor _____ Date :_____