TAMBRINI FAMILY DENTISTRY
Seth A. Tambrini, D.D.S.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you maybe taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever been hospitalized or had a major operation?	Yes ☐	No ☐
Do you take, or have you taken, bisphosphonate drugs for osteoporsis, bone tumors, or any other reason? (e.g. Fosomax, Boniva, etc)	Yes ☐	No ☐
Do you use tobacco products?	Yes ☐	No ☐
Do you consume alcoholic beverages on a daily basis?	Yes ☐	No ☐
Have you had any cardiac valves repaired or replaced?	Yes ☐	No ☐
Have you had a history of infective endocarditis?	Yes ☐	No ☐
Have you ever had a joint(s) replaced?	Yes ☐	No ☐

What, if any, medications are you currently taking? Please list medication name, dosage (if known), and frequency:

_____

_____

_____

Are you alergic to any of the following?

☐ No Drug Allergies ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal
☐ Local Dental Anesthetics ☐ Sulfa Drugs ☐ Other (please specify) _____

Women: Are you

Pregnant ☐ Yes ☐ No Taking Oral Contraceptives ☐ Yes ☐ No Nursing ☐ Yes ☐ No

Do you have, or have you had, any of the following? ***(Please circle Y for YES and N for NO)***

AIDS/HIV Positive	Y N	Cortizone Medicine	Y N	Hemophilia	Y N	Psychiatric Care	Y N
Alzheimer's Disease	Y N	Diabetes	Y N	Hepatitis	Y N	Radiation Treatments	Y N
Anaphylaxis	Y N	Emphysema	Y N	High Blood Pressure	Y N	Renal Dialysis	Y N
Anemia	Y N	Epilepsy or Seizures	Y N	Hypoglycemia	Y N	Rheumatoid Arthritis	Y N
Angina	Y N	Excessive Bleeding	Y N	Irregular Heartbeat	Y N	Sicke Cell Disease	Y N
Arthritis/Gout	Y N	Fainting Spells/Dizziness	Y N	Leukemia	Y N	Spina Bifida	Y N
Asthma	Y N	Frequent Cough	Y N	Liver Disease	Y N	Stomach/Intestinal Disease	Y N
Cancer	Y N	Glaucoma	Y N	Low BloodPressure	Y N	Stroke	Y N
Chemotherapy	Y N	HayFever/Seasonal Allergies	Y N	Lung Disease	Y N	Swelling of Limbs	Y N
Chest Pain	Y N	Heart Attack	Y N	Lupus	Y N	Thyroid Disease	Y N
Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Congenital Heart Disease	Y N	Heart Pacemaker	Y N	Parathyroid Disease	Y N		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient (parent or guardian) _____ DATE _____