Bonar Family Dentistry, LLC
Medical History

Name: **Date:**

Answer all questions by circling Yes (Y) or No (N)

1. Has there been any change in your general health in the last year?	Y N	m.) Radiation X-Ray treatment for cancer?	Y N
2. Date of last physical exam	Y N	n.) TMJ (popping of jaw joint, clicking, pain, difficulty opening mouth, grind, clech teeth)?	Y N
3. Are you now under a physician's care for a problem?	Y N	o.) Sinus/Nasal Problems?	Y N
4. Have you ever had any serious illnesses, operations, or hospitalizations? If so, describe	Y N	p.) Do you have any removable dental or sleep appliance (occlusal guard, partial, denture, orthodontic retainers, snore guard, sleep apnea device)?	Y N
5. Height: Weight:			
6. Do you have or have you ever had:		q.) Do you snore or have you been diagnosed with sleep apnea?	Y N
a.) Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Mitral Valve Prolapse, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, Rheumatic Fever or Rheumatic Heart Disease)?	Y N	7. Are you allergic to or have you ever had an adverse reaction to:	Y N
		a.) Local Anesthesia (Novocain, etc)?	Y N
b.) Congenital Heart Disease?	Y N	b.) Antibiotics: Penicillin, Amoxicillin, Cephalexin, erthromycin, clarithromycin, azithromycin, ciprofolxacin, levofloxacin, ofloxacin?	Y N
c.) Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest pain)?	Y N	c.) Sedatives, barbiturates, sulfities?	Y N
d.)Seizures, Convulsions, Epilepsy, fainting or dizziness?	Y N	d.) Asprin, Ibuprfen, Tylenol	Y N
e.) Bleeding Disorder (Anemic, bleeding tendency, blood transfusion, bruise easily)?	Y N	e.) Codeine, Hydrocodone, oxycodone, morphine?	Y N
f.) Liver Disease (Jaundice, Hepatitis)?	Y N	f.) Latex or rubber products?	Y N
g.) Kidney Disease	Y N	8. Do you use any of the following	Y N
h.) Diabetes?	Y N	a.) Tobacco (smoke or chew tobacco, vape)	Y N
i.) Thyroid Disease (Goiter)?	Y N	b.) Recreational drugs: (marijuana, cocaine, heroin, methamphetamines, etc) Please list:	Y N
j.) Arthritis?	Y N		
k.) Glaucoma	Y N	c.) Is there current or past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?	Y N
l.)Implants (artificial joints, heart valve, pacemaker, hip, knee)?	Y N		
ll.)Do you have or have your ever been pre-medicated with an antibiotic prior to dental treatment?	Y N	9. Have you had any serious problems associated with any previous dental treatment?	Y N

10. Have you or an immdeiate family member had any problem associated with anesthesia?	Y N
11. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?	Y N
12. Do you wish to talk to the doctor privately about anything?	Y N
13. Any disease, drug, or transplant operation that has depressed your immune system?	Y N
14. Have you had your wisdom teeth removed?	Y N
15. Have you had orthodontia (braces or invisalign)?	Y N

FOR WOMEN ONLY:	Y N
16. Are you pregnant or is there a chance you might be pregnant?	Y N
17. Are you nursing?	Y N
18. If you are using oral contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control after/during the course of antibiotics or other medication. Please consult your physician for futher guidance.	Y N

Medications	
Are you using any of the following?:	
a.) Antibiotics	Y N
b.) Anticuagulants (warfarin, blood thinners, etc.)	Y N
c.) Aspirin, Ibuprofen, Aleve, Tylenol	Y N
d.) High Blood Pressure medication	Y N
e.) Steroids (cortisone, prednisone, etc.)	Y N
f.) Tranquilizers	Y N
g.) Bisphosphonate (osteoporosis)	Y N
h.) Insulin or Anit-Diabetic drugs	Y N
i.) Digitalls, Inderal, Nitoglycerin, high blood pressure, or other heart medication	Y N
j.) Vitamins	Y N

k.) Please list all medications:	

By signing below you understand the importance of providing a truthful health history in order to assist the doctor in providing the best possible care.

Patient Signature:	BP: / Pulse:
Doctor Signature:	