Waco Dental and Denture Care, P.A.
Dr. Dana W. Chudej, DDS, FAGD
901 N. Loop 340, Suite 5
Waco, Texas 76705
(254) 799-5000

Today's Date: _____

ID: _____

Chart ID: _____

Patient Medical History

Patient Name: _____ Date of Birth: _____

Please complete this form so we can best assess your medical history in preparation of your upcoming dental treatment. Thank you for your attention to detail.

If the answer is 'yes' to any of the following questions, please explain in the space provided.

☐ yes ☐ no Are you under a physician's care now? _____
☐ yes ☐ no Have you ever been hospitalized or had a major operation? _____
_____
☐ yes ☐ no Have you ever had a serious head or neck injury? _____
☐ yes ☐ no Are you taking medications, pills, or drugs? _____
☐ yes ☐ no Do you take, or have you taken, Phen-Fen or Redux? _____
☐ yes ☐ no Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? _____
☐ yes ☐ no Are you on a special diet? _____
☐ yes ☐ no Do you use tobacco? _____
☐ yes ☐ no Do you use controlled substances? _____

Women Patients:
☐ Are you pregnant/trying to get pregnant? ☐ Are you taking oral contraceptives? ☐ Are you nursing?

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs ☐ Other

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐yes ☐no	Drug Addiction	☐yes ☐no	High Cholesterol	☐yes ☐no
Alzheimer's Disease	☐yes ☐no	Emphysema	☐yes ☐no	Leukemia	☐yes ☐no
Anemia	☐yes ☐no	Epilepsy or Seizures	☐yes ☐no	Liver Disease	☐yes ☐no
Angina	☐yes ☐no	Excessive Bleeding	☐yes ☐no	Low Blood Pressure	☐yes ☐no
Arthritis/Gout	☐yes ☐no	Fainting Spells/Dizziness	☐yes ☐no	Mitral Valve Prolapse	☐yes ☐no
Artificial Heart Valve	☐yes ☐no	Frequent Headaches	☐yes ☐no	Osteoporosis	☐yes ☐no
Artificial Joint	☐yes ☐no	Heart Attack/Failure	☐yes ☐no	Pain in Jaw Joints	☐yes ☐no
Asthma	☐yes ☐no	Heart Murmur	☐yes ☐no	Psychiatric Care	☐yes ☐no
Blood Disease	☐yes ☐no	Heart Pacemaker	☐yes ☐no	Radiation Treatments	☐yes ☐no
Cancer	☐yes ☐no	Heart Trouble/Disease	☐yes ☐no	Rheumatic Fever	☐yes ☐no
Chest Pains	☐yes ☐no	Hemophilia	☐yes ☐no	Scarlet Fever	☐yes ☐no
Cold Sores/Fever Blisters	☐yes ☐no	Hepatitis A	☐yes ☐no	Sickle Cell Disease	☐yes ☐no
Congenital Heart Disorder	☐yes ☐no	Hepatitis B or C	☐yes ☐no	Sinus Trouble	☐yes ☐no
Convulsions	☐yes ☐no	Herpes	☐yes ☐no	Stroke	☐yes ☐no
Diabetes	☐yes ☐no	High Blood Pressure	☐yes ☐no	Thyroid Disease	☐yes ☐no
				Tuberculosis	☐yes ☐no

Have you ever had any serious illness not listed above? ☐ yes ☐ no
Comments: _____
_____
_____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Today's Date: _____