Dr. Michael R. Callahan

MEDICAL HEALTH:

PATIENT NAME:_____ DATE OF BIRTH_____ DATE_____

Name, address and phone number of your Physician:_____

Name and phone number of your pharmacy:_____

Date of last physical examination:_____ Reason for examination:_____

What is your estimate of your general health? (Please Circle) Excellent Good Fair Poor

Are you under the care of a physician now? Yes ☐ No ☐ If so, why?_____

Have you been hospitalized within the last 5 years? Yes ☐ No ☐ If yes, when and for what reasons?_____

_____

Have you ever had any major operations? If so, for what? When?_____

Have you had abnormal bleeding after cuts, surgery, or dental extractions? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐ Pipe_____ Cigars_____ Snuff_____ Cigarettes_____ Packs Daily_____

DO YOU OR HAVE YOU EVER BEEN INFORMED YOU HAVE ANY OF THE FOLLOWING:
(Please check or circle YES or NO.)

Yes No
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Rheumatic or Scarlet Fever
- ☐ ☐ Heart Murmur or Heart Birth Defects
- ☐ ☐ Rheumatic Heart Disease
- ☐ ☐ Infective Endocraditis
- ☐ ☐ Artificial Heart Valves
- ☐ ☐ Cardiac Pacemaker
- ☐ ☐ Heart Attack
- ☐ ☐ High Blood Pressure (If yes, is it controlled? Yes or No.)
- ☐ ☐ Angina (Chest Pain)
- ☐ ☐ Stroke
- ☐ ☐ Irregular Heart Beat or Heart Ailment
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Kidney Disease
- ☐ ☐ Kidney Transplant
- ☐ ☐ Diabetes — Insulin Dependent_____ Controlled (diet, medications)_____
- ☐ ☐ Hypoglycemia or Hyperglycemia
- ☐ ☐ Hormonal Problems
- ☐ ☐ Excessive urination (more than 6 times per day)?_____
- ☐ ☐ Excessive thirst?
- ☐ ☐ Do you have a family history of diabetes? Who?_____
- ☐ ☐ Do you experience slow healings of wounds or sores?
- ☐ ☐ Headaches (more than 3 a month)

Yes No
- ☐ ☐ Fainting Spells or Dizziness
- ☐ ☐ Sickle Cell Anemia
- ☐ ☐ Hemophilia
- ☐ ☐ Prolonged bleeding problems
- ☐ ☐ Leukemia
- ☐ ☐ Other Blood Disorders_____
- ☐ ☐ Respiratory or Lung Disease
- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema
- ☐ ☐ Swelling of feet and ankles
- ☐ ☐ Do you require extra pillows when you sleep or experience shortness of breath?
- ☐ ☐ Persistent, productive cough
- ☐ ☐ Asthma (Do you use an inhaler? Yes or No.)
- ☐ ☐ Liver Disease
- ☐ ☐ Hepatitis Type_____
- ☐ ☐ Corticosteroid Therapy or other immunosuppressive therapy

OTHER
- ☐ ☐ Epilepsy or Seizures
- ☐ ☐ Artificial Joint Replacement (hip, knee, joints)
- ☐ ☐ Implant / Prosthetic Pins or Rods
- ☐ ☐ Lupus
- ☐ ☐ Arthritis
- ☐ ☐ Gout
- ☐ ☐ Hearing Aide
- ☐ ☐ Sinus Trouble
- ☐ ☐ Thyroid or Parathyroid Problems
- ☐ ☐ Allergies

Yes No
- ☐ ☐ Glaucoma or other eye problems
- ☐ ☐ Contact Lens
- ☐ ☐ Frequent Fevers
- ☐ ☐ Recurrent Sore Throat
- ☐ ☐ Enlarged Lymph Nodes
- ☐ ☐ Persistent Diarrhea
- ☐ ☐ Night Sweats
- ☐ ☐ Skin Rashes
- ☐ ☐ Stomach Ulcers (If yes, were they bleeding ulcers? Yes or No.)
- ☐ ☐ AIDS or HIV
- ☐ ☐ Sexually transmitted diseases (venereal disease, syphilis, genital herpes, etc.)
- ☐ ☐ Bruise easily
- ☐ ☐ Psychiatric treatment
- ☐ ☐ Neurological Disorders
- ☐ ☐ Emotional Problems or Depression
- ☐ ☐ Generally a nervous person
- ☐ ☐ Tumor or Abnormal Growth
- ☐ ☐ Chronic Fatigue
- ☐ ☐ Muscular Disorders
- ☐ ☐ History of Fever Blisters, Canker Sores, or Cold Sores
- ☐ ☐ Alcohol / Drug Dependency
- ☐ ☐ Family History of Mouth Cancer
- ☐ ☐ History of Face or Skin Cancer
- ☐ ☐ Chemotherapy or Radiation Treatments

WOMEN: **(Please check)** Pregnant / Trying to get pregnant: Yes ☐ No ☐ Nursing: Yes ☐ No ☐ Taking birth control pills: Yes ☐ No ☐

MEN: Do you have any known prostate disorders? Yes ☐ No ☐

Please list any other serious illnesses, medical treatments, or any treatments that may affect your dental care_____

Do you wish to talk to the dentist privately about any problems? Yes ☐ No ☐

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING SUBSTANCES:
- ☐ Local Anesthetic (such as Novacaine)
- ☐ Codeine
- ☐ Sedatives, Barbiturates, or Sleeping Pills
- ☐ Acrylic
- ☐ Latex Rubber
- ☐ Nitrous Oxide Gas (Laughing Gas)
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Aspirin
- ☐ Sulfa Drugs
- ☐ Metals (gold, stainless steel, etc.)
- ☐ Fluoride
- ☐ Other_____

CURRENT MEDICATIONS (please list) _____

_____

To the best of my knowledge, all of the preceding questions are correct. If I have any changes in my medical health or medications I will notify the dentist and staff without fail.

_____ _____

Patient Signature (or Responsible Adult if a minor) Date

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— PLEASE COMPLETE BOTH SIDES —

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