Michael L. La Puma, D.M.D.
MEDICAL/DENTAL HEALTH HISTORY

Patient Name _____ Age _____

Date of Birth _____ Height _____ Weight_____

Occupation _____

If you are completing this form for another person, what is your relationship to that person?

_____

Please Check an Answer for each Question Below:

1. Are you in good health?…… Yes ☐ No ☐
2. Are you now, or have you been, under the care of a physician during the past five years (not including annual exams)?…… Yes ☐ No ☐
3. Date of last dental exam? _____ Date of last medical exam? _____
4. Have you ever been a patient in a **hospital**?…….…….. Yes ☐ No ☐
   Reason for and approximate dates of hospitalizations:
   _____
   _____
5. Have you taken any **drugs** or **medications** in the past year? ……..…… Yes ☐ No ☐ ●
   Please list medications and dosages you are taking now or attach your own list:
   _____
   _____
6. Have you ever used any **blood thinner** medications? ……..… Yes ☐ No ☐ ●
7. Are you currently using any GLP-1 medications ie: Ozempic, Wegovy?. ..... Yes ☐ No ☐
8. Have you ever used any of the bisphosphonate bone density enhancing medications? (Fosamax)..... Yes ☐ No ☐
9. Do you have any **allergies** or **sensitivities** to medications? Please List: Yes ☐ No ☐ ●
   _____
   9a. Do you have any allergy to latex? .....Yes ☐ No ☐
10. Have you had local anesthesia? (numb) ……..…….....…. Yes ☐ No ☐
11. Have you had general anesthesia? (sleep) ……..... Yes ☐ No ☐ ●
12. Do you now or have you ever used any device to help you breath during sleep? (C-Pap)... Yes ☐ No ☐ ●
13. Are you subject to excessive bleeding? ……...……. Yes ☐ No ☐
14. Do you have, or have you had, any of the following problems?
    a. Pain in chest upon exertion ……. Yes ☐ No ☐
    b. Short of breath after mild exercise…… Yes ☐ No ☐
    c. Ankles swell ……. Yes ☐ No ☐
    d. Short of breath when lying down, or requiring an extra pillow when sleeping ……...… Yes ☐ No ☐
15. Do you have difficulty opening your mouth widely? ……... Yes ☐ No ☐
16. Have you ever had an injury to the face or jaws? …… Yes ☐ No ☐
17. Do you have any numbness or tingling sensations in any part of your body? ……. Yes ☐ No ☐
18. Have you ever received any radiation, chemotherapy, or surgical treatment for a tumor, growth, or other condition about your head, mouth, lips, or other parts of your body? …. Yes ☐ No ☐
19. Are you on dialysis? ……. Yes ☐ No ☐
20. Do you wear contact lenses? How many:_____ …….. Yes ☐ No ☐
21. Do you have a cough, cold, or sinus problem at present? …… Yes ☐ No ☐
22. Are you a cigarette smoker? ……. Yes ☐ No ☐
23. Do you chew tobacco? ……...…….. Yes ☐ No ☐

24. Women:

a. Are you pregnant? …… Yes ☐ No ☐

b. If so, how many months? _____

c. Are you nursing? ……. Yes ☐ No ☐

d.Are you on any form of birth control? ……... Yes ___ No ___

25. **Please Circle an Answer for Each Condition Below:**

Heart Failure	Yes	No
Heart Disease or Attack	Yes	No
Angina Pectoris (Chest Pain)	Yes	No
High Blood Pressure	Yes	No
Heart Murmur	Yes	No
Rheumatic Fever	Yes	No
Damaged Heart	Yes	No
Artificial Heart Valves	Yes	No
Mitral Valve Prolapse	Yes	No
Heart Surgery	Yes	No
Artificial Joint	Yes	No
Anemia	Yes	No
Stroke	Yes	No
Kidney Trouble	Yes	No
Ulcers	Yes	No
Bruise Easily	Yes	No
Emphysema	Yes	No
Cough	Yes	No
Tuberculosis (TB)	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Sinus Trouble	Yes	No
Allergies or Hives	Yes	No
Sickle Cell Disease	Yes	No

Malignant Hyperthermia	Yes	No
Diabetes	Yes	No
Thyroid Disease	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Arthritis	Yes	No
Cortisone Medicine	Yes	No
Glaucoma	Yes	No
Pain in Jaw	Yes	No
Hepatitis A (Infectious)	Yes	No
Hepatitis B (Serum)	Yes	No
Liver Disease	Yes	No
AIDS/HIV Positive	Yes	No
Yellow Jaundice	Yes	No
Blood Transfusion	Yes	No
Drug or Alcohol Problems	Yes	No
Hemophilia	Yes	No
S.T.D. or S.T.I. (Syphilis, Gonorrhea, Herpes)	Yes	No
Cold Sores	Yes	No
Epilepsy or Seizures	Yes	No
Fainting or Dizzy Spells	Yes	No
Nervousness	Yes	No
Psychiatric Treatment	Yes	No

26. Do you have **any disease, condition**, or **problem** not listed above that you think we should know about? If so, please explain: Yes ☐ No ☐

_____

27. Do you have planned or have you recently undergone any medical procedures? Yes ☐ No ☐

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or my medicines change, I will inform the doctor at the next appointment without fail.

Signature of Patient, Parent, or Guardian: _____ Date: _____

OFFICE USE **B/P P R**

Reviewed by (Doctor):_____ Date: _____ _____

Date	Additions/Changes	Pt. Initials	Review By (Dr.)	Vital Signs (B/P P R)