Coastal Dental Services <<<o>>> Dentures & *More*

Southside Office -- 4402 Old Salisbury Road

Jacksonville, Florida 32216

Tele: (904) 296-7757 <<<o>>> Fax: (904) 296-0147

www.FLDental.com

CONFIDENTIAL MEDICAL HISTORY

PATIENT: _____

ARE YOU NOW UNDER CURRENT MEDICAL TREATMENT?: Yes ○ No ○
If yes, what is the condition for which are you being treated? _____
ARE YOU TAKING MEDICATION PRESCRIBED FOR YOU BY ANOTHER DOCTOR?_____: Yes ○ No ○
If yes, list the medication/drugs you are taking on the Medical History Supplement Sheet of this packet?: Yes ○ No ○
ARE YOU ON ANTICOAGULANTS (Blood thinners)?_____ : Yes ○ No ○
ARE YOU TAKING BISPHOSPHONATES present or past (Boniva, Actonel, Fosamax, Adrenolate): Yes ○ No ○
HAS A PHYSICIAN EVER INFORMED YOU THAT YOU HAVE OR HAD:

- A Heart/Cardiac Ailment or Condition (Including Angina?_____: Yes ○ No ○
- Have you had a Heart Attack, Stroke or any other Cardio/Vascular Accident?_____: Yes ○ No ○
- Do you have a Heart murmur, or other congenital heart lesion?_____: Yes ○ No ○
- Have you had Rheumatic Fever, or had a joint replacement?_____: Yes ○ No ○
- Has a physician ever told you that you require antibiotics prior to dental treatment or surgery? Yes ○ No ○
- High Blood Pressure?_____: Yes ○ No ○
- Respiratory Disease (Emphysema, Asthma, TB, COPD?_____: Yes ○ No ○
- Diabetes?_____: Yes ○ No ○
- Rheumatic Fever or Heart Valve Condition?_____: Yes ○ No ○
- Any Blood Disease, dyscrasia, or condition (Including Anemia)?_____: Yes ○ No ○
- Liver Disease, Yellow Jaundice, or Hepatitis (Type:_____)? _____: Yes ○ No ○
- Kidney disease or condition?_____: Yes ○ No ○
- Do you have arthritis? (if so, is it Rheumatoid ☐ Osteo Arthritis ☐ : Yes ○ No ○
- Cancer or tumor requiring treatment or surgery?_____: Yes ○ No ○
- Glaucoma or Ulcers?_____: Yes ○ No ○
- Are you H.I.V. positive or have the A.I.D.S. complex ?_____: Yes ○ No ○
- Do you now, or have you had sinus problems?_____: Yes ○ No ○
- Do you now, or have you ever had, a substance abuse problem (including alcohol, prescription drugs or recreational/street drugs)? _____: Yes ○ No ○
- Are you now, or have you ever been, on chronic pain control therapy?_____: Yes ○ No ○
- Do you smoke, or use any other tobacco product? Yes ○ No ○ if so, how long_____ #/day?_____
- If former smoker or smokeless tobacco user, how long since you quit?_____

HAVE YOU EVER HAD AN ALLERGIC (or ADVERSE) REACTION TO PENICILLIN, ASPIRIN, CODEINE, LOCAL ANESTHETIC, LATEX, OR ANY OTHER MATERIAL OR DRUG? _____: Yes ○ No ○
ARE YOU ALLERGIC TO ANY MATERIAL(s) RESULTING IN SKIN RASH, HIVES, or BREATHING PROBLEMS?_____: Yes ○ No ○
HAVE YOU BEEN TO A HOSPITAL EMERGENCY ROOM WITHIN THE PAST 5 YEARS?____: Yes ○ No ○
HAVE YOU HAD ANY SURGERY (DENTAL OR MEDICAL)? If so, use reverse side to describe: Yes ○ No ○
ARE YOU IN GENERAL GOOD HEALTH AT THIS TIME?_____: Yes ○ No ○
HAVE YOU EVER HAD: Local Anesthetic (Novocaine)? _____: Yes ○ No ○

- Any adverse reaction to local anesthesia? _____: Yes ○ No ○

DO YOU CONSIDER YOURSELF A "FREE BLEEDER" OR HAVE YOU BEEN TOLD BY ANY DOCTOR THAT YOU HAVE A "BLEEDING PROBLEM"; OR WHEN YOU CUT YOURSELF, DO YOU BLEED FOR AN EXCESSIVE LENGTH OF TIME OR HAVE DIFFICULTY CONTROLLING BLEEDING?__: Yes ○ No ○

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I hereby attest to the information listed above as to its accuracy and correctness – If there is any change in my health or medications, I will inform the doctor or his assistant prior to any treatment. By signing this form I authorize release of medical information to associated medical/dental providers, insurance companies of which I am an insured, &/or other entities legally authorized by Florida State Law to possess my medical/dental treatment & condition records.

Signature:_____ Date:_____

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CONFIDENTIAL MEDICAL HISTORY – Supplement Sheet

PATIENT: _____

Question #:	**Explanation or listing of medications, surgeries, or Physician's Contact Information:**