PATIENT MEDICAL HISTORY

Benjamin T. Peterson, DDS

Patient Name: _____ Date of Birth: _____

*e-mail address:*_____ *Contact Phone#:* _____

Medical Physician's Name: _____ Date of last medical exam: _____

Are you currently under medical treatment? ☐ Yes ☐ No If yes, please explain: _____

Have you been hospitalized for any surgical operation or serious illness in the last 5 years? ☐ Yes ☐ No
If yes, please briefly explain and give dates: _____

Have you ever taken medication for Osteoporosis? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No
Do you suffer from daytime sleepiness? ☐ Yes ☐ No
Have you ever been diagnosed with a sleep disorder or sleep apnea? ☐ Yes ☐ No
Have you had a sleep study? ☐ Yes ☐ No
Have you failed a CPAP? ☐ Yes ☐ No

Are you allergic to or have you had any reactions to the following:

Local anesthetics	☐ **Yes** ☐ **No**	**Sulfa drugs**	☐ **Yes** ☐ **No**
Penicillin	☐ **Yes** ☐ **No**	**Any metals**	☐ **Yes** ☐ **No**
Codeine	☐ **Yes** ☐ **No**	**Latex rubber**	☐ **Yes** ☐ **No**

Other: _____

Women Only:
Are you pregnant or think you might be pregnant? ☐ Yes ☐ No If Yes, estimated due date: _____
Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No

Please list any medications you are taking, including non-prescribed medications, and the dosage you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Low blood pressure	☐	☐	Epilepsy/convulsions	☐	☐	Hepatitis/Jaundice	☐	☐
High blood pressure	☐	☐	Diabetes	☐	☐	Sexually Trans Disease	☐	☐
Heart Attack	☐	☐	Kidney disease	☐	☐	AIDS/HIV	☐	☐
Heart Disease	☐	☐	Thyroid problems	☐	☐	Ulcer/Stomach Trouble	☐	☐
Artificial heart valve	☐	☐	Respiratory problems	☐	☐	Stroke	☐	☐
Heart murmur	☐	☐	Emphysema	☐	☐	Cancer	☐	☐
Mitral valve prolapse	☐	☐	Hay fever/Allergies	☐	☐	Radiation therapy	☐	☐
Pacemaker	☐	☐	Anemia	☐	☐	Recent weight loss	☐	☐
Circulatory problems	☐	☐	Back problems	☐	☐	Liver disease	☐	☐
Fainting/Seizures	☐	☐	Arthritis	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Artificial joints	☐	☐	Other: _____		
Tobacco use	☐	☐	Weight loss medication	☐	☐			

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Blood Press Pulse

_____ _____ _____ _____
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_____ _____ _____ _____
Signature of Patient or Responsible Party Date Blood Press Pulse