Jay W. Dorgan, DDS, FAGD

FELLOW: Academy of General Dentistry

DDS: University of Maryland, Baltimore College of Dental Surgery, Baltimore, MD

MEMBER: American Academy of Cosmetic Dentistry, Academy of Osseointegration, American Dental Association, Pennsylvania Dental Association, Delaware–Chester County Dental Society

AWARDS: Named Top Family/ Cosmetic Dentist 2007, *Main Line Today*

ALUMNUS: L.D. Pankey Institute for Advanced Dental Education, Dawson Center for Advanced Dental Study, Seattle Institute for Advanced Dental Education

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HEALTH HISTORY

Today's Date: _____ / _____ / _____
month day year

OFFICIAL USE ONLY
PRE-MED: Yes _____ No _____
COMMENTS: _____
_____
_____

Patient's Name: _____ Date of Birth: _____ / _____ / _____
month day year

Physician's Name: _____

Physician's Address: _____

Physician's Telephone: (_____) _____-_____

Date of your most recent visit to Physician: _____ / _____ / _____
month day year

Reason: _____

How would you assess your general Health? Good: _____ Fair: _____ Poor: _____

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

1. Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition? Yes _____ No _____
2. Have you been hospitalized within the last year? Yes _____ No _____
   If yes, explain: _____
   _____
3. Have you had a serious illness or operation within the last year? Yes _____ No _____
   If yes, explain: _____
   _____
4. Have you ever had any serious medical trouble associated with any dental experience? Yes _____ No _____
   If yes, explain: _____
   _____
5. Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? Yes _____ No _____
   If yes, explain: _____
   _____

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HEALTH HISTORY - page 2

Do you now or have you had any of the following diseases or problems? Yes _____ No _____

Cardiovascular Disease: Yes _____ No _____
If yes, check any that apply:

❒ Heart disease ❒ Hardening of the arteries ❒ Heart attack ❒ High blood pressure ❒ Coronary bypass
❒ Stroke ❒ Angina ❒ Heart murmur ❒ Mitral valve prolapse ❒ Congestive heart failure

Rheumatic fever or rheumatic heart disease Yes _____ No _____

Congenital heart defects Yes _____ No _____

Prosthetic (artificial) heart Yes _____ No _____

Pacemaker? Yes _____ No _____
*If yes, date of placement:*_____

Do you have chest pain upon exertion? Yes _____ No _____

Do your ankles swell? Yes _____ No _____

Do you get short of breath when you lie down? Yes _____ No _____

Abnormal bleeding or extended clotting time? Yes _____ No _____

Frequent or unexpected nose bleeds? Yes _____ No _____

High cholesterol Yes _____ No _____

High blood pressure Yes _____ No _____

Diabetes? Yes _____ No _____ If yes, do you require insulin? Yes _____ No _____ Type and Dose: _____

Do you have an artificial joint? Yes _____ No _____ If yes, which joint(s)? _____

Hepatitis? Yes _____ No _____

If yes, please check type.

❒ Type A ❒ Type B ❒ Type C ❒ Non-Specific Type ❒ Don't know ❒ Other: _____

Have you ever required a blood transfusion? Yes _____ No _____ If yes, what was the date of the transfusion? _____

Are you HIV positive? Yes _____ No _____

Do you have any reason to suspect that you have been exposed to the HIV virus? Yes _____ No _____

Have you ever had Tuberculosis (TB)? Yes _____ No _____

Have you ever had a TB test? Yes _____ No _____

Do you have a cough that has lasted more than 3 weeks? Yes _____ No _____

Do you ever cough up blood? Yes _____ No _____

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HEALTH HISTORY - page 3

PLEASE CHECK ANY THAT APPLY:

- ❒ Allergies
- ❒ Anemia
- ❒ Asthma
- ❒ Autoimmune Disease
- ❒ Cancer
- ❒ Chronic/ Recurring
- ❒ Cirrhosis
- ❒ Diabetes
- ❒ Eating Disorder
- ❒ Glaucoma
- ❒ Herpes
- ❒ Jaundice or Liver Disease
- ❒ Kidney Disease
- ❒ Osteoporosis
- ❒ Radiation Treatment
- ❒ Serious/Frequent Headaches
- ❒ Skin Problems
- ❒ Ulcers
- ❒ Alzheimer's Disease
- ❒ Angina
- ❒ Arthritis
- ❒ Blood Disorder
- ❒ Chemo Therapy
- ❒ Sinus Problems
- ❒ Depression
- ❒ Drug or Alcohol Treatment
- ❒ Epilepsy or Other Seizures
- ❒ Heart Disease
- ❒ HIV / AIDS
- ❒ Joint Replacement
- ❒ Organ Transplant
- ❒ Parkinson's Disease
- ❒ Respiratory Problems
- ❒ Sexually Transmitted Disease
- ❒ Tuberculosis
- ❒ Other_____

Do you consider yourself currently under an abnormally high amount of stress? Yes _____ No _____

Have you had any unexplained or unplanned weight loss recently? Yes _____ No _____

When was your last complete physical exam with your medical doctor, including blood tests? Yes _____ No _____

Do you now or have you ever smoked? Yes _____ No _____

❒ *Cigarettes* ❒ *Pipe* ❒ *Cigar* ❒ *Other* _____

If you currently smoke, how much? _____

If you have smoked in the past but no longer smoke, when did you quit? _____

Do you chew tobacco? Yes _____ No _____ *If yes, how often?* _____

Do you drink alcohol? Yes _____ No _____ *If yes, how much?* _____

WOMEN:

Are you currently pregnant? Yes _____ No _____ *If yes, expected delivery date* _____

Do you have regular gynecological checkups? Yes _____ No _____

Have you reached menopause? Yes _____ No _____

Are you currently on hormone replacement therapy? Yes _____ No _____

Have you had a mammogram? Yes _____ No _____ *If yes, date of last mammogram* _____

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HEALTH HISTORY - page 4

If you are currently taking these medications, check the box on the left.
If you have taken any of these medications within the past year, but are not taking them currently, check the box on the right.

Now	Past Year		Now	Past Year	
❒	❒	Antibiotics	❒	❒	Antidepressants (Prozac, Zoloft, etc.)
❒	❒	Antihistamines	❒	❒	Blood Pressure Medicine
❒	❒	Blood Thinners	❒	❒	Cortisone (Prednisone, etc.)
❒	❒	Cholesterol Medication	❒	❒	Decongestants
❒	❒	Diuretics (water pills)	❒	❒	Hormones (birth control pills, estrogen)
❒	❒	Inhalants	❒	❒	Insulin
❒	❒	Medicine for Heart Problems	❒	❒	Muscle Relaxants
❒	❒	Nitroglycerine	❒	❒	Pain Medicine (Aspirin, Advil, Tylenol, etc.)
❒	❒	Prescription Pain Medication	❒	❒	Sleeping Pills
❒	❒	Thyroid Medicine	❒	❒	Tranquilizers
❒	❒	Vitamins	❒	❒	Others _____

Are you *ALLERGIC* to any of the following medications (do you get hives, a rash, have trouble breathing, etc.):

❒ Antibiotics (penicillin, tetracycline, etc .) ❒ Local Dental Anesthetics (novocaine) ❒ Codeine ❒ Aspirin
❒ Barbiturates or Sedatives ❒ Tranquilizers ❒ Others _____

Have you ever had an adverse reaction like nausea, dizziness, or feeling "spacey" with any drug or medication? Yes _____ No _____
Do you have any disease, condition or problem not previously listed that you feel we should know about? Yes _____ No _____

Signature: _____ Today's Date _____ / _____ / _____
month / day / year

Print Name: _____

Notes: _____

_____

_____

_____

_____

BP: _____

RESP: _____

PULSE: _____