Scott F. Bobbitt, DMD, MAGD
Restorative, Laser and Implant Dentistry
Snoring and Sleep Apnea Therapy

MEDICAL HISTORY

(PERSONAL AND CONFIDENTIAL)
Update needed every 5 yrs or event based

Name: _____

Date of Birth: ____/____/_____

1. Primary Care Physician's (PCP) Name: _____
   PCP office address: _____
   a. Date of last physical: _____
   b. Any conditions you are currently being treated for: _____
   _____
2. Have you been hospitalized in the last five (5) years: ……..…… Yes No
   a. When? _____ Reason? _____
3. Are you taking any medications? (Prescription, OTC, herbal, illicit, vitamins, other)……..... Yes No
   a. If yes, please list: _____
   _____
4. Have you had an allergic reaction to any medication, metal, latex or jewelry? ……..…… Yes No
   a. If yes, which ones? _____
5. Have you ever used diet drugs (*e.g.* Redux, Phenfen) ……..……. Yes No
   a. If yes, have you had an ultrasound heart exam? ……..…….. Yes No
6. Have you had trouble with prolonged bleeding after surgery? ……..……..…… Yes No
7. Have you ever been diagnosed with cancer or a tumor? ……..……..…… Yes No
   a. If yes, your diagnosis: _____
   b. Did you receive chemotherapy? ……. Yes No Radiation therapy? ……... Yes No
   c. Date of last treatment: Month _____ Year_____
8. Have you ever taken medications for osteoporosis? ……..…… Yes No
9. Please check if you have ever used: Tobacco? E-cigarettes? Marijuana? Smokeless Tobacco?
10. Please check, if yes, how much did/do you use? _____ cigarettes packs cans times blunts per day for ____Years
    a. If you are an ex-user, what year did you quit? _____
11. Do you have any history with the following conditions? Please check or circle EACH response, as appropriate:

Heart Attack ……...	Yes	No	GERD/Reflux/Heartburn	Yes	No	Substance Abuse ……	Yes	No
Heart Murmur …….....	Yes	No	Snoring/Sleep Apnea.....	Yes	No	Hepatitis ……..……..	Yes	No
Heart Valve Problem…..	Yes	No	Daytime Sleepiness …..	Yes	No	AIDS/HIV …….....	Yes	No
Rheumatic Fever …….....	Yes	No	CPAP Use ……..	Yes	No	HPV ……...	Yes	No
Heart Disease …….....Yes		No	Asthma ……...	Yes	No	Tuberculosis ……...	Yes	No
Heart Surgery ……....	Yes	No	Arthritis …….....	Yes	No	Blood Transfusion…..…	Yes	No
High Blood Pressure …...Yes		No	Allergies/Hives ……...	Yes	No	Anemia ……...	Yes	No
Pacemaker ... …….....	Yes	No	Emphysema …….....	Yes	No	Taking Blood thinners ...	Yes	No
Angina Pectoris ……..…	Yes	No	Dry Mouth ……..……..	Yes	No	Bruise Easily …….....	Yes	No
Stroke …….	Yes	No	Gum/Mouth Surgery …..	Yes	No	Bleeding Problems ….....	Yes	No
Diabetes …….....Yes		No	Epilepsy/Seizures ……..	Yes	No	Psychiatric Care ……....Yes		No
Ulcers …….……....	Yes	No	Fainting/Dizziness ….....Yes		No	Anxiety/Depression ……	Yes	No
Kidney Trouble …….....	Yes	No	Cold Sores ……...…...	Yes	No	Autoimmune Disorder….Yes		No
Thyroid Problem..……...	Yes	No	Artificial Joints ……...	Yes	No			

Details, if needed: Continued on back □

12. Do you have any history of disease, condition or problem not listed above? ……..... Yes No
If yes, please list here: _____
13. **WOMEN:** Are you pregnant? …Yes No Nursing? ……Yes No Taking Birth Control Pills? ... Yes No

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

X_____ **Date:** _____ **Staff:** _____

(Signature of patient, parent, or guardian)

EMERGENCY CONTACT (Name and phone number): _____

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