Scott F. Bobbitt, DMD, MAGD

Restorative, Laser and Implant Dentistry
Snoring and Sleep Apnea Therapy

MEDICAL HISTORY

(PERSONAL AND CONFIDENTIAL)

Name: ______________________________________

Date of Birth: _________/_____/_________

Please Circle

1. Are you under the care of a physician? ………………………………………………………….……………….. Yes No
   a. If yes, for what treatment or reason: ____
   b. Primary Care Physician's (PCP) Name: ____
   c. Primary Care Physician's (PCP) Address: ____
   d. Date of last physical: ____
   e. Are you in good health? ………………………………………………………………………………… Yes No
2. Have you been hospitalized in the last five (5) years: ……………………………………………….……… Yes No
   a. When? ________________ Reason? ____
3. Are you taking any medications? (prescription, over-the-counter, herbal, illicit, vitamins, other)……….... Yes No
   a. If yes, please list here: ____
   ____
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, what was 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. Have you ever used tobacco products? ………………………………………………………………...….... Yes No
   a. If yes, how much did/do you smoke? ___________ Packs per day for ________Years
   b. If you are an ex-smoker, what year did you quit? ____________________________
10. Please circle "Yes" or "No" for any of the following conditions you may have or have had in the past:

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

11. Do you have any disease, condition or problem not listed above? ……………………………….…....Yes No
    a. If yes, please list here: ____
12. **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): ____

FOR STAFF USE