Bruce A. Kanehl, D.D.S

Reset Form

Email Form

Medical History

Patient Name: _____ Date of Birth: _____

Physicians Name: _____ Phone Number: _____

Date of Last Exam: _____

Have you had any serious illnesses or operations?
Please Explain: _____

Are you currently under the care of a Physician? _____ If so, Why_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV	☐ Hepatitis	☐ Anemia	☐ Asthma	☐ Joint Replacement
☐ Mitral Valve Prolapse	☐ Diabetes	☐ Radiation Treatment	☐ Heart Disease	☐ Tuberculosis
☐ Skin Rash	☐ Swelling of Legs or Ankles	☐ Heart Murmur	☐ Transplant Prostheses	☐ High Blood Pressure
☐ Pacemaker	☐ Epilepsy	☐ Rheumatic Fever	☐ Migraines	☐ Chemical Dependencies
☐ Latex Sensitive	☐ Allergic to Nickel	☐ Nervous Disorders	☐ Sexually transmitted disease	☐ Snoring
☐ Sleep disorder	☐ Sleep Apnea			

List any allergies you may have:

_____

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? _____
If so, what antibiotic and dose? _____

Do you take a bone-building drug such as Fosamax, Actonel, Zometa, Aredia or Pamidronate? _____
If so, orally or IV? _____

For Women Only:
Is there a possibility that you are currently pregnant? _____ If so, due date _____

Are you taking birth control pills or hormonal replacement? _____

Do you currently use tobacco? _____
If so, for how long? _____ Do you want to quit? _____

Do you drink alcoholic beverages? _____
If so, how much alcohol did you drink in the last 24 hours? _____ in the past week? _____

Are you alcohol and/or drug dependent? _____
If so, have you received treatment? _____

List medications you are taking currently if any, including herbal and vitamin supplements:

_____

Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain:

_____

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I have reviewed the information in this questionnaire, and it is accurate to the best of my knowledge. I understand the importance of all the above information and that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signature of patient, parent or guardian _____ Date _____