FREDERICK L. STEINBECK
D.D.S. M.D.
627 Highland Ave
Ft. Thomas, KY 41075

MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

Answer the following questions as accurately as possible. This form is confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. What was the date of your last physical exam? ____/____/____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Have you had surgery of any kind? ..... Yes No
   Have you ever been to sleep with anesthesia? ..... Yes No
   If so were there any problems with anesthesia? Please list:
   _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Rheumatic Heart Disease ..... Yes No
   c. Heart trouble, heart attack, angina, arteriosclerosis, heart surgery, or other heart conditions..... Yes No
      1. Chest pain upon exertion? ..... Yes No
      2. Shortness of breath after mild exercise? ..... Yes No
      3. Do your ankles swell? ..... Yes No
   d. High blood pressure ..... Yes No
   e. Stroke ..... Yes No
   f. Asthma, emphysema, bronchitis or other breathing problems ..... Yes No
   g. Persistent cough or cough that produces blood ..... Yes No
   h. Hepatitis, jaundice or liver disease ..... Yes No
   i. Diabetes ..... Yes No
   j. Sleep Apnea. ..... Yes No
   k. Kidney trouble ..... Yes No
   l. Seasonal allergies or sinus trouble ..... Yes No
   m. Fainting spells or seizures ..... Yes No
   n. Frequent or recurring mouth sores ..... Yes No
   o. Thyroid problems ..... Yes No
   p. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
   q. Stomach ulcer or hyperacidity ..... Yes No
   r. Persistent swollen neck glands ..... Yes No
   s. Low blood pressure ..... Yes No
   t. Epilepsy or neurological disorder ..... Yes No
   u. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
   v. Cancer, tumor, or growth ..... Yes No
   w. Temporomandibular Joint (TMJ) pain or clicking or chronic head ache ..... Yes No
9. Have you had abnormal bleeding or anemia of any kind? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
10. Do you smoke or have you smoked in the last 5 years? ..... Yes No

11. Do you currently use chewing tobacco or have you used it in the past? ..... Yes No
12. Do you currently drink alcohol? ..... Yes No
13. Are you taking any medicine(s) including non-prescription or "natural" remedies or diet pills ..... Yes No
    If so please list:

    _____

    _____

14. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other ..... Yes No
15. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____

    _____
16. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
17. Have you ever taken oral bisphosphonates (i.e. Fosamax, Boniva, Actonel, etc) for any reason? ..... Yes No
    Have you ever been given IV bisphosphonates (i.e. Zometa, Reclast, etc) for any reason? ..... Yes No
18. Are you wearing contact lenses? ..... Yes No
19. Are you wearing removable dental appliances? ..... Yes No
20. Do you wish to talk with the doctor privately about anything? ..... Yes No

The following questions are for women only:

21. Are you pregnant or trying to become pregnant ..... Yes No
22. Are you nursing? ..... Yes No
23. Are you taking birth control pills? ..... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.

Date: _____ Patient's Signature: _____

FOR COMPLETION BY THE DOCTOR

Comments: _____

_____

_____

Date: _____ Doctor's Signature: _____

Medication List:

PLEASE LIST ALL CURRENT MEDICATIONS

Additional health history notes:

FREDERICK L. STEINBECK
D.D.S. M.D.
627 Highland Ave.
Ft. Thomas, KY 41075