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Medical History

The following questions concerning your medical history and health are vital in planning your treatment, choosing medication, and insuring your health and well-being. Please answer all questions below as completely as possible. All information will be held in strict confidence. Your cooperation is necessary and appreciated.

Please answer each question by circling a yes, no or leave blank if unsure.

1. Do you consider yourself to be in good health?: **Y** **N**

2. Are you currently under the care of a physician?: **Y** **N**
If yes, for what? _____

3. Are you currently on any medication or drugs? **Y** **N**
What is the name of it? _____ What is the name of it? _____
How long have you been on it? _____ How long have you been on it? _____
What is it prescribed for? _____ What is it prescribed for? _____
What is the dosage? _____ What is the dosage? _____
How many times a day do you take it? _____ How many times a day do you take it? _____
Do you expect to remain on it long term? _____ Do you expect to remain on it long term? _____
(Please use the other side of this sheet for any other medications.)

4. Do you currently take an aspirin daily? (this includes baby aspirin) **Y** **N**

5. Do you take antibiotics before dental appointments? (for heart murmur or joint replacement) _____

6. Do you have any allergies? (for medications or other) **Y** **N**
If yes, to what? _____

My last medical examination was on: _____

The name and address of my physician is: Telephone #: () -

7. Has there been any change in your health in the past year? **Y** **N**
Please explain: _____

8. Have you had any serious illness or operation? **Y** **N**
If yes, what & when? _____

9. Have you ever had a serious accident? **Y** **N**
What was the extent of the injuries? _____

10. Have you ever had any of the following illnesses? **Y** **N**
If yes, please circle which one(s)

- a. Rheumatic fever, rheumatic heart disease or murmur
- b. Cardiovascular disease (high blood pressure, heart disease, stroke)
- c. Allergies, asthma, skin rash, hives
- d. Fainting spells or seizures
- e. Diabetes or kidney disease
- f. Hepatitis, yellow jaundice of liver disease
- g. Arthritis, joint disease, artificial joints
- j. bleeding or clotting problems/disorders, anemia
- k. Cancer, tumor, growths
- l. AIDS, ARC, HIV infection
- m. Respiratory disease, sinus infections
- n. Drug or alcohol dependency
- o. Chemotherapy or radiation treatment
(excluding diagnostic x-rays for fractures and dental treatment)

(Continued on next page)

11. Have you ever had an adverse, bad, or allergic reaction to: **Y N**

If yes, please circle which one(s) and briefly note problem.

- a. Surgery
- b. Dental Treatment
- c. Medicines
- d. Penicillin or other antibiotics
- e. Local anesthetics (Novocaine, Lidocaine, Epinephrine)
- f. Codeine, aspirin, or other pain relief medications

12. Do you have any disease, condition, or problem not listed above? **Y N**

If yes, what? _____

13. (For women) Are you currently or do you suspect you might be pregnant? **Y N**

14. Do you smoke? **Y N**

If yes, how much per day? _____

15. Do you use chewing tobacco? **Y N**

This is to certify that I consent and hereby authorize, and request the performance, upon myself or minor child, an dental procedure advisable or necessary. I also authorize and request the administration of local anesthetic(s) (such as Novocaine, Lidocaine) as deemed necessary or advisable by the doctor. I fully understand that dental medicine and surgery is not an exact science and that a precise outcome or perfect result cannot be guaranteed. I understand and acknowledge that I am financially responsible for the services provided regardless of insurance coverage.

Signature: _____ Date: _____

Parent's (or Guardian's) signature if patient is under 18 years old.

Notes/Additional Information: _____

(for office use)

review of medical hx	/	/	_____
update of medical hx	/	/	_____
update of medical hx	/	/	_____
update of medical hx	/	/	_____
update of medical hx	/	/	_____