Compass Health Network

Patient Medical History

Patient Name:_____ Date of Birth: _____

Primary Care Physician: _____ Facility Name: _____

Date of last exam: _____ Are you under care of a specialist? _____

	Yes	No		Yes	No
1. Are you under medical treatment now by a primary care physician or specialty doctor?	☐	☐	8. Do you use tobacco products?	☐	☐
2. Have you been hospitalized, or have you had any surgeries in the last 5 years? If yes, please explain. _____ _____	☐	☐	9. Do you use a vape?	☐	☐
			10. Do you use controlled substances including marijuana/recreational drugs?	☐	☐
3. Please list all prescription and non-prescription medications you are taking, including any herbal supplements. _____ _____	☐	☐	11. Do you have a history of drug/alcohol abuse?	☐	☐
4. Have you ever taken bisphosphonate therapy (pills or injections for bone strengthening such as Fosamax, Boniva) for osteoporosis or cancer?	☐	☐	12. Are you currently feeling like harming yourself and/or others?	☐	☐
5. Are you currently taking any blood thinners or undergoing anticoagulant therapy? (e.g. Coumadin, Plavix, Eliquis, Aspirin)	☐	☐	13. Are you pregnant or think you may be? If yes, due date: _____	☐	☐
6. Do you have bleeding problems or have ever had any prolonged bleeding following a surgical procedure??	☐	☐	14. Are you nursing?	☐	☐
7. Do you have any disabilities? If yes, please explain: _____	☐	☐	15. Are you taking oral contraceptives(birth control)?	☐	☐

Are you allergic to or have you had any reactions to the following?

	Yes	No	If yes, what is the reaction?
Local Anesthetics (e.g. Lidocaine or Septocaine)	☐	☐	
Penicillin/Amoxicillin	☐	☐	
Other Antibiotics	☐	☐	
Other Medications	☐	☐	
Barbiturates	☐	☐	
Sedatives	☐	☐	
Iodine	☐	☐	
Aspirin	☐	☐	
Any metals (e.g. nickel, mercury, etc)	☐	☐	
Latex Rubber	☐	☐	
Codeine	☐	☐	
Red Dye	☐	☐	
Other Allergies:	☐	☐	

_____ *(patient/guardian initials)* I acknowledge that the above information is accurate.

Doctor's Initials ☐ Date ☐

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Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Mitral Valve Prolapse	☐	☐	Fainting	☐	☐	Arthritis	☐	☐
Heart Disease/Heart Failure	☐	☐	Epilepsy/Convulsions/Seizures	☐	☐	Osteoporosis	☐	☐
Heart Surgery	☐	☐	Cancer	☐	☐	Joint Replacement or Implant	☐	☐
Heart Attack	☐	☐	Leukemia	☐	☐	Back/Neck Problems	☐	☐
Heart Murmur	☐	☐	Radiation Therapy	☐	☐	Thyroid Problem	☐	☐
Chest Pains/Angina	☐	☐	Chemo Radiation Therapy	☐	☐	Kidney Disease	☐	☐
Cardiac Pacemaker	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever/Allergies	☐	☐	Hepatitis	☐	☐
Low Blood Pressure	☐	☐	Respiratory Problem	☐	☐	Jaundice	☐	☐
Stroke	☐	☐	Emphysema/COPD	☐	☐	Stomach/Intestinal Troubles	☐	☐
Blood Clots	☐	☐	Asthma	☐	☐	Acid Reflux	☐	☐
Swollen Ankles	☐	☐	Tuberculosis	☐	☐	Ulcers	☐	☐
Anemia	☐	☐	AIDS or HIV Infection	☐	☐	ADHD	☐	☐
Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Autism	☐	☐
Recent Weight Loss	☐	☐	Herpes Simplex Virus 1	☐	☐	Other(please list below)	☐	☐

Please list any specific conditions or information that may pertain to your diagnosis above(example, if diabetic A1C Number):

_____

_____

Patient Dental History

Name of Previous Dentist & Location: _____ Date of Last Exam: _____

Preferred Pharmacy & Location: _____

	Yes	No
1. Are your teeth important to you?	☐	☐
2. Do you feel pain in any of your teeth?	☐	☐
3. Do you clench or grind your teeth?	☐	☐
4. Have you had any head, neck, or jaw injuries?	☐	☐
5. Do you have any swelling in jaw or mouth?	☐	☐
6. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐

What are your overall expectations/goals for your oral health? _____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize the dental provider to reach out to a physician. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date