O'LEARY DENTAL OFFICE

Kevin S. O'Leary, D.D.S.

MEDICAL HISTORY NEW PATIENT EVALUATION

PATIENT'S NAME: _____ **DOB:** _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES / NO

If yes, please explain: _____

Name of Treating Physician: _____

LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____ _____
_____ _____
_____ _____
_____ _____

LIST VITAMINS / SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES TO MEDICATIONS:

_____ _____
_____ _____
_____ _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

A.I.D.S. / A.R.C. / HIV	Epilepsy / Seizures	Neurological Disorder
Alcoholism	Fainting / Dizziness	Psychiatric / Mental Health Issues
Allergic Reactions (medications)	Fever Blisters	Pain in Jaw Joints
Anemia	Glaucoma	Radiation Therapy
Angina Pectoris	Heart Disease or Attack	Rheumatic Fever
Artificial Heart Value	Heart Murmur	Shortness of Breath / COPD
Artificial joints / hips / knees	Heart Pacemaker	Sickle Cell
Arthritis / Rheumatism	Hemophilia	Sinus Trouble
Asthma / Hay fever / Allergies	Hepatitis A / B / C	Stroke
Blood transfusions	High / Low Blood Pressure	Swelling / Edema
Bruise Easily	Liver Disease	Tonsil / Adenoid Problems
Chemotherapy	Jaundice	Thyroid Disease
Diabetes	Kidney Problems	Tuberculosis
Drug addictions	Mitral Valve Prolapse	Ulcers
Emphysema	Nervousness / Anxiety	Veneral Disease

REVISED 07/15/16 JD

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MEDICAL HISTORY NEW PATIENT EVALUATION

DIET / HEALTH

Do you frequently skip breakfast?	YES / NO	
Is your diet medically supervised?	YES / NO	
Have you had significant weight change in last year?	YES / NO	# of Lbs lost: _____
Do you take vitamin or mineral supplements?	YES / NO	
Do you drink coffee?	YES / NO	# of cups per day: _____
Do you drink soda / pop, energy drinks?	YES / NO	# per day: _____
Do you exercise daily?	YES / NO	
Explain what your exercise consists of: _____		
Do you smoke or use tobacco products?	YES / NO	# per day: _____
Do you use a vapor pipe?	YES / NO	# of times used per day: _____
Do you drink alcoholic beverages?	YES / NO	# per day: _____

SLEEP HABITS

Do you sleep with more than two (2) pillows?	YES / NO
Do you sleep with your bed elevated ?	YES / NO
Do you sleep well?	YES / NO
Do you wake up frequently throughout the night?	YES / NO
Do you sleep with a sleeping mask on?	YES / NO
Do you sleep with ear plugs in your ears?	YES / NO
Do you fatigue easily?	YES / NO
Do you snore?	YES / NO
Do you have trouble breathing when you sleep?	YES / NO
Do you wear a sleep-apnea device?	YES / NO

OTHER PERTINENT MEDICAL ISSUES

Please write in any other pertinent information that may not have been covered in the above areas:

_____

_____

AUTHORIZATION: I hereby authorize Dr. O'Leary and / or his dental staff to administer, diagnostic tests and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The medical history and information provided is given to the best of my knowledge. I also authorize the doctor and/or dental staff to contact my healthcare providers concerning my treatment as necessary.

X_____ _____

Patient Signature or Guardian's Signature **Date**

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