Bergmann and Hohm Dental Group
N50 W34770 Wisconsin Avenue ◆ Okauchee, WI 53069 ◆ 262-567-0770

Patient Name: ____ Phone: _______________

Medical Information

Answers to the following questions are for our records only and will be considered confidential.

General Health — yes/no

Are you now under the care of a physician? ☐ ☐

Physician name and phone:

Are you in good health? ☐ ☐

Date of last physical exam:

Has there been any change in your general health within the past year? ☐ ☐

If yes, what condition is being treated?

Have you had a serious illness, operation or been hospitalized in the past five (5) years? ☐ ☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ ☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

____
____
____
____
____
____
____
____

Women Only

Are you pregnant? ☐ ☐

If so, number of weeks? ____________________

Do you think you might be pregnant? ☐ ☐

Are you nursing? ☐ ☐

Do you take birth control or hormonal replacement? ☐ ☐

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Allergies — yes/no

Are you allergic to or have you had a reaction to:
(for all **yes** responses, specify type of reaction)

Local anesthetics ☐ ☐
____
Aspirin ☐ ☐
____
Penicillin or other antibiotics ☐ ☐
____
Barbiturates, sedatives, or sleeping pills ☐ ☐
____
Sulfa drugs ☐ ☐
____
Codeine or other narcotics ☐ ☐
____
Metals ☐ ☐
____
Latex (rubber) ☐ ☐
____
Iodine ☐ ☐
____
Hay fever/seasonal ☐ ☐
____
Animals ☐ ☐
____
Food ☐ ☐
____
Other ☐ ☐
____

Current Conditions

Do you wear contact lenses? ☐ ☐

Are you taking, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine) or phen-fen (fenflluramine-phentermine)? ☐ ☐

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis? ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from multiple myeloma or metastatic cancer? ☐ ☐

Do you use controlled substances (drugs)? ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐

If so, how interested are you in stopping?
Circle one: VERY/ SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐

If so, how much alcohol did you drink in the last 24 hours? ____________________

If so, how much do you typically drink in a week?
____

Continue on reverse side >>>

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Medical History

Have you had or not had any of the following diseases or problems:

	yes/no		yes/no
Heart murmur	☐ ☐	Chronic pain	☐ ☐
Mitral valve prolapse	☐ ☐	Diabetes Type I or II	☐ ☐
Artificial heart valves	☐ ☐	Eating disorder	☐ ☐
Rheumatic fever	☐ ☐	Malnutrition	☐ ☐
Cardiovascular disease	☐ ☐	Gastrointestinal disease	☐ ☐
Angina	☐ ☐	G.E. Reflux/persistent heartburn	☐ ☐
Arteriosclerosis	☐ ☐	Ulcers	☐ ☐
Congestive heart failure	☐ ☐	Thyroid problems	☐ ☐
Coronary artery disease	☐ ☐	Stroke	☐ ☐
Heart attack	☐ ☐	Glaucoma	☐ ☐
Low blood pressure	☐ ☐	Hepatitis, jaundice or liver disease	☐ ☐
High blood pressure	☐ ☐	Epilepsy	☐ ☐
Congenital heart defects	☐ ☐	Fainting spells or seizures	☐ ☐
Pacemaker	☐ ☐	Neurological disorders	☐ ☐
Rheumatic heart disease	☐ ☐	If yes, specify: ______________________________	
Anemia	☐ ☐	Sleep disorder	☐ ☐
Blood transfusion	☐ ☐	Mental health disorders	☐ ☐
If yes, date: _________________	☐ ☐	Specify: ____________________________________	
Hemophilia	☐ ☐	Recurrent infections	☐ ☐
AIDS or HIV infection	☐ ☐	Type of infection: ____________________________	
Arthritis	☐ ☐	Kidney problems	☐ ☐
Autoimmune disease	☐ ☐	Night sweats	☐ ☐
Rheumatoid arthritis	☐ ☐	Osteoporosis	☐ ☐
Systemic lupus erythematosus	☐ ☐	Persistent swollen glands in neck	☐ ☐
Asthma	☐ ☐	Severe headaches/migraines	☐ ☐
Bronchitis	☐ ☐	Severe or rapid weight loss	☐ ☐
Emphysema	☐ ☐	Sexually transmitted disease	☐ ☐
Sinus trouble	☐ ☐	Excessive urination	☐ ☐
Tuberculosis	☐ ☐		
Cancer/Chemotherapy/Radiation Treatment	☐ ☐		
Chest pain upon exertion	☐ ☐		

Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐

If so, date: _________________________________

Have you had any complications? ☐ ☐

Please explain.

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐

If so, name and phone of physician or dentist making recommendation:

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ ☐

If so, please explain:

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To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's Signature: ____ Date: ____________________

Recall Review

1. Patient's Signature: ____ Date: ____________________

2. Patient's Signature: ____ Date: ____________________

3. Patient's Signature: ____ Date: ____________________

4. Patient's Signature: ____ Date: ____________________