Charles A. Mastrovich D.D.S., A.P.C.
911 East Grand Avenue
Escondido, CA 92025-3403

LAST NAME_____ FIRST NAME _____ INITIAL _____

The medical information below has been requested for your safety. Your complete answers will assist us in providing for any of your special medical needs during the delivery of dental services.
PLEASE CIRCLE AND / OR FILL IN THE APPROPRIATE ANSWER FOR EACH NUMBER.

1. CIRCLE APPROPRIATE ANSWER (Please leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain: _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes No Have you gone to the hospital, had surgery or a serious illness in the last three years?
   If YES, explain: _____
4. Yes No Are you being treated by a physician now? If YES, explain
   Date of last medical exam? Reason for exam: _____
5. Yes No Are you taking any medications or drugs now?
   If yes, please list below:

Drug	Purpose	Dosage and Frequency	1st Prescribed	Prescribing Doctor

2. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Coughing up blood	Ringing in ears	Dry mouth
Fainting spells	Bleeding problems	Headaches	Excessive thirst
Recent significant weight loss or gain	Blood in urine	Dizziness	Swollen ankles
	Blood in stool	Blurred vision	Joint pain or stiffness
Fever	Diarrhea or constipation	Bruise easily	Shortness of breath
Night sweats	Frequent urination	Frequent vomiting	Sinus problem
Persistent cough	Difficulty urinating		

3. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	Diabetes	Artificial joint	Skin disease
Stroke	Asthma	Stomach problems or ulcers	Cosmetic surgery
Heart attack	Emphysema or other lung disease		Tumors or cancer
Heart defects		Seizures	Chemotherapy
Heart murmurs	Kidney or bladder disease	Arthritis, rheumatism	Radiation
Rheumatic fever	Thyroid disease	Eating disorders	AIDS/HIV
Hardening of the arteries	Hepatitis	Psychiatric care	Sexually transmitted disease
High blood pressure	Jaundice	Osteoporosis	
Transplants	Liver disease	Eye disease	Herpes
Pacemaker	Tuberculosis	Blood Disorders	Canker or cold sores

4. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Local Dental Anesthetic	Food	Advil	Percodan
Latex	Penicillin	Aleve	Demerol
Nitrous Oxide	Erythromycin	Codeine	Darvon
Acrylic	Tetracycline	Vicodin	Environmental _____
Metal	Aspirin	Valium	Other _____
Sulfa	Iodine	Keflex	

(Please continue on reverse)

MEDICAL HISTORY

I. "Recreational" or "Street" drugs such as cocaine, marijuana, stimulants, or depressants may have severe or even fatal interaction with local anesthetics or other dental medications. Please describe below any use of these drugs, or confidentially discuss with Dr. Mastrovich. _____

II. Do you use tobacco products? ..... YES NO

- ☐ Smoking: ____ packs per day for approximately____years
- ☐ Tobacco (in any form)

III. Do you consume alcoholic beverages? ..... YES NO

- ☐ Approximate number of drinks per week: ____

IV. Do you have or have you had any other diseases or medical problems NOT listed on this form? ..... YES NO
If YES, explain: _____

V. Have you ever been pre-medicated for dental treatment? ..... YES NO
If YES, explain: _____

VI. Have you ever taken Fen-phen? ..... YES NO
If YES, explain: _____

VII. Have you taken Bisphosphonates (Fosamax)? ..... YES NO

VIII. Are there any issues or conditions that you would like to discuss with Dr. Mastrovich in private? ..... YES NO

WOMEN ONLY

IX. Are you or could you be pregnant? ..... YES NO
If YES, what month: _____

X. Are you nursing? ..... YES NO

XI. Are you taking birth control pills? ..... YES NO

RESERVED FOR OFFICE USE

History notes by: _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist/staff to contact my physician.

Patient's Signature: _____ Date: _____
Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medications. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

Medical Updates: I have reviewed my history above and confirm it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials