Cody Dental Group

Confidential Medical History

Patient Name:_____Birthdate_____Today's date_____

Name and Address of your medical Physician:_____
_____Date of last physical_____

PLEASE CIRCLE CORRECT ANSWER:

YES NO Are you under the care of a physician? If yes, for what? _____
YES NO Any major illness or surgery? If yes, please be specific; include date_____
YES NO Are you taking any drugs/medications (e.g., cortisone, aspirin, vitamins, anticoagulant, etc..)?
_____
YES NO Any recent weight gain of loss?
YES NO Do you use any form of tobacco products (cannabis oil, marijuana, vaping, cigarettes, chew, cigars, etc?) _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? If yes, please describe under remarks.

YES	NO		YES	NO	
___	___	AIDS or AIDS related disease (HIV)	___	___	Radiation
___	___	Alcoholism	___	___	Sinusitis
___	___	Allergies or Drug reactions_____	___	___	Snoring ___ Snoring Device Y N
___	___	Anemia	___	___	Sleeping Difficulties
___	___	Arthritis or Autoimmune disease	___	___	Spina Bifida
___	___	Asthma	___	___	Stomach or Digestive problems (ulcers)
___	___	Bleeding problems	___	___	Stroke
___	___	Breathing problems (shortness of breath)	___	___	Swelling of Feet or Ankles
___	___	Emphysema	___	___	Tuberculosis
___	___	Cancer/Tumor (treatment, chemo, surg.,)	___	___	Venereal Disease
___	___	Diabetes Type:_____			**ANY UNDISIREABLE REACTIONS TO:**
___	___	Dry Mouth/Dry Eyes	___	___	Local Anesthetics (Novocaine, etc)
___	___	Endocrine disturbances (Thyroid, etc.)	___	___	Oral surgery or Tooth extractions
___	___	Epilepsy, Convulsions, Seizures	___	___	Penicillin or other Antibiotics:
___	___	Fainting			_____
___	___	Frequent headaches	___	___	Other Drugs or Medicines
___	___	Hay Fever/Environmental Allergies			_____
___	___	Heart Trouble, Damage, Murmur	___	___	Latex Allergy
___	___	High Blood Pressure			**WOMEN:**
___	___	Chest Pains	___	___	Are you taking Birth Control pills?
___	___	Artificial Heart Valves-date_____	___	___	Are you now pregnant? ____months
___	___	Artificial Joints: date_____	___	___	Are you nursing?
___	___	PRE-Medication Required for Heart/Joints			**REMARKS:**_____
___	___	Rheumatic Fever			_____
___	___	Herpes			_____
___	___	Hepatitis: Type___ Liver Disease/Jaundice			_____
___	___	Kidney or Urinary problems			_____
___	___	Psychological or emotional problems			_____

Patient Signature_____ Date_____. CDG Staff initial_____