HFD
HAMMOUD
FAMILY DENTAL

Omran Hammoud, D.D.S.
5777 West Maple Rd., Suite 160, West Bloomfield, MI 48322
248-851-2980

MEDICAL HISTORY

PATIENT NAME: _____

Whom may we thank for referring you to our office? _____

Physician's Name _____ **Phone Number** _____

Have you ever been hospitalized or had a major surgery? ☐ **Yes** ☐ **No**

Please list: _____

Are you taking any prescription or over-the-counter medications? ☐ **Yes** ☐ **No**

Please list: _____

_____

_____

Women: Are you ☐ **Using hormone based contraceptives?** ☐ **Pregnant/Trying?** ☐ **Nursing?**

Are you taking Fosamax, Boniva, Actonel, or similar medications? ☐ **Yes** ☐ **No**

Are you using any controlled substances? ☐ **Yes** ☐ **No**

Do you use tobacco or medical marijuana? ☐ **Yes** ☐ **No**

Have you ever taken antibiotics before dental appointments? ☐ **Yes** ☐ **No**

Have you ever had a serious head or neck injury? ☐ **Yes** ☐ **No**

Do you use a CPAP machine? ☐ **Yes** ☐ **No**

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal
☐ Latex	☐ Local Anesthetics	☐ Ibuprofen	☐ Sulfa Drugs	☐ Other_____

Current or past history of:

☐ Acid Reflux	☐ Chest Pains/Angina	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ AIDS/HIV Positive	☐ Cold Sores	☐ Heart Attack/Disease	☐ Liver Disease	☐ Sinus Issues/Hay Fever
☐ Alzheimer's/Dementia	☐ Cortisone Medication	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sleep Apnea
☐ Anaphylaxis	☐ Diabetes	☐ Heart Pace Maker	☐ Lung Disease	☐ Spina Bifida
☐ Anemia	☐ Drug Addiction	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Stroke
☐ Arthritis/Gout	☐ Emphysema	☐ Hepatitis A, B or C	☐ Osteoporosis	☐ Swelling of Limbs
☐ Artificial Heart Valve*	☐ Epilepsy/Seizures	☐ Herpes	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Artificial Joint*	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Psychiatric Care	☐ Tonsilitis
☐ Asthma	☐ Excessive Thirst	☐ High Cholesterol	☐ Radiation Treaments	☐ Tuberculosis
☐ Blood Disease	☐ Fainting/Dizziness	☐ Hives or Rash	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Breathing Problems	☐ Frequent Cough	☐ Hypoglycemia	☐ Renal Dialysis	☐ Ulcers
☐ Bruise Easily	☐ Frequent Diarrhea	☐ IBS/Colitis	☐ Rheumatic Fever	☐ Venereal Disease
☐ Cancer	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Rheumatism	☐ Yellow Jaundice
☐ Chemotherapy	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles	☐ Other

***Antibiotic premedication may be required prior to your appointment**

Emergency Contact : _____ **Phone Number :** _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian **Date**

I have reviewed my health history today and have made any necessary changes to my health and/or medications.

DATE	PATIENT INITIALS	STAFF INITIALS