

MEDICAL HISTORY FORM

Date _____

Name _____ Home Phone _____
Last First Middle

Address _____ Cell Phone _____ Bus. Phone _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth _____ Sex M F Height _____ Weight _____ Single _____ Married _____

Name of Spouse _____ Closest Relative _____ Phone _____

If you are completing this form for another person, what is your relationship to that person?

Referred By _____

For the following questions, circle *yes* or *no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Are you in good health?..... Yes No

Has there been any change in your general health within the past year? Yes No

My last physical examination was on _____

Are you now under the care of a physician? Yes No

If so, what is the condition being treated? _____

The name and address of my physician(s) is _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years?..... Yes No

If so, what was the illness or problem? _____

Are you taking any medication(s) including non-prescription medicine?..... Yes No

If so, what medicine(s) are you taking? _____

Do you smoke?..... Yes No

Do you have or have you had any of the following diseases or problems?

Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease..... Yes No

Cardiovascular disease (heart troubles, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No

Do you have chest pain upon exertion?..... Yes No

Are you ever short of breath after mild exercise or when lying down?..... Yes No

Do your ankles swell? Yes No

Do you have inborn heart defects? Yes No

Do you have a cardiac pacemaker?..... Yes No

Allergy Yes No Sinus trouble Yes No

Asthma or Hay Fever Yes No Fainting spells/seizures Yes No

Persistent diarrhea or recent weight loss Yes No Diabetes Yes No

AIDS or HIV Yes No Hepatitis, Jaundice or liver disease Yes No

Thyroid problem Yes No Stomach ulcer or Hyperacidity Yes No

Respiratory problems, emphysema, bronchitis, etc. Yes No Arthritis or painful swollen joints Yes No

Kidney trouble Yes No Tuberculosis Yes No

Persistent cough or cough That produces blood Yes No Persistent swollen glands in neck Yes No

Low blood sugar Yes No Sexually transmitted disease Yes No

Epilepsy or other neurological disease Yes No Problems with mental health Yes No

Cancer Yes No Problems of the immune System Yes No

Have you had abnormal bleeding?..... Yes No

Have you ever required a blood transfusion? Yes No

Do you have any blood disorder such as anemia? Yes No

Have you ever had any treatment for a tumor or growth?..... Yes No

Are you allergic or have you had a reaction to:

Local anesthetics Yes No Penicillin or other Antibiotics Yes No

Sulfa drugs Yes No Barbiturates, sedatives or sleeping pills Yes No

Aspirin Yes No Iodine Yes No

Codeine or other narcotics Yes No Other Yes No

Have you had any serious trouble associated with any previous dental treatment? Yes No

If so, explain _____

Do you have any disease, condition or problem not listed above that you think I should know about? Yes No

If so, explain _____

Are you wearing contact lenses? Yes No

Are you wearing removable dental appliances? Yes No

Women:

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Chief Dental Complaint _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. 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.

Date _____ Signature of Dentist _____