Medical History Form

Name _____ Nickname_____

Date of Birth_____ Sex M F Height_____ Weight_____

For the following questions, circle *YES* or *NO,* whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? _____ Yes No
2. Has there been any change in your general health within the past year?_____ Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? _____Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is
   _____
6. Have you had any serious illness, operation or been hospitalized within the past 5 years? _____ Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s)including non-prescription medicine? _____ Yes No
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? _____ Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) _____ Yes No
      1. Do you have chest pain upon exertion?_____Yes No
      2. Are you ever short of breath after mild exercise or when lying down? _____ Yes No
      3. Do your ankles swell? _____ Yes No
      4. Do you have inborn heart defects? _____ Yes No
      5. Do you have a cardiac pacemaker?_____ Yes No
   c. Asthma or hay fever _____Yes No
   d. Respiratory problems, emphysema, bronchitis, etc. _____ Yes No
   e. Tuberculosis _____ Yes No
   f. Viral infections and cold sores _____Yes No
   g. Diabetes _____ Yes No
   h. Glaucoma _____ Yes No
   i. Hepatitis, jaundice, or liver disease _____ Yes No
   j. Sexually transmitted disease _____Yes No
   k. Aids or HIV infection_____ Yes No
   l. Kidney trouble _____ Yes No
   m. Stomach ulcer or hyperacidity _____Yes No
   n. Thyroid problems _____ Yes No
   o. Low blood pressure _____ Yes No
   p. Arthritis or painful, swollen joints _____ Yes No
   q. Problems of the immune system _____ Yes No
   r. Epilepsy or other neurological disease _____ Yes No
   s. Fainting spells or seizures _____Yes No
   t. Persistent diarrhea or recent weight loss _____ Yes No
   u. Cancer _____Yes No
   v. Persistent cough or cough that produces blood _____Yes No
   w. Lumps or swelling in mouth _____Yes No
   x. Persistent swollen glands in neck _____Yes No
   y. Radiation therapy or chemotherapy _____Yes No

9. Have you had abnormal bleeding? _____ Yes No
10. Have you ever required a blood transfusion? _____ Yes No
11. Do you have any blood disorder such as anemia? _____ Yes No
12. Have you ever had any treatment for a tumor or growth? _____ Yes No
13. Are you allergic or have you had a reaction to:
    a. Local anesthetics _____ Yes No
    b. Penicillin or other antibiotics _____ Yes No
    c. Sulfa drugs _____ Yes No
    d. Barbiturates, sedatives or sleeping pills _____ Yes No
    e. Aspirin _____ Yes No
    f. Iodine _____ Yes No
    g. Codeine or other narcotics _____ Yes No
    h. Other _____
14. Have you had any problems with mental health? _____ Yes No
15. Have you had an alcohol or drug dependency? _____ Yes No
16. Do you use tobacco products? _____ Yes No
17. Are you wearing contact lenses? _____ Yes No
18. Do you have any disease, condition, or problem not listed above that you think I should know about? _____ Yes No
    If so, explain _____

Women

19. Are you pregnant? _____ Yes No
20. Are you nursing? _____ Yes No
21. Are you taking birth control pills? _____ Yes No

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 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 _____ Date _____

Parental Signature if minor_____ Date _____

For completion by the dentist.

Significant findings from questionnaire or oral interview: _____

_____

_____

DDS int. & Date _____

Medical history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____