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
   z. Acid Reflux/GERD ____________ 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

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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: ____________________

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DDS int. & Date ____________

Medical history update:

Date	Comments	Signature
______	____________________	____________
______	____________________	____________
______	____________________	____________
______	____________________	____________
______	____________________	____________
______	____________________	____________
______	____________________	____________
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