Medical History Form

Name _____ Home phone _____

Address_____ Business phone _____

City_____ State_____ _____ Zip code _____

Email: _____ Cell phone: _____

Date of Birth _____ Sex: M F Height_____ Weight _____ Single _____ Married _____

Employer: _____ Social Security No.:_____

Name of Spouse_____ Closest Relative _____ Phone _____

If completing this form for a person, what is your relationship to the patient? _____

Referred by? _____

For the following, 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 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 in the past 5 years?.....yes….no
   If so, what was the illness?_____
7. **Please list all medicines that you are currently taking including non-prescription medicines.**

   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
8. **Are you currently taking any type of blood thinner?.....yes….no**
9. **Have you ever taken bisphosphonate drugs such as Boniva or Fosamax?.....yes…no**
10. **Do you smoke or use any type of tobacco products?_____yes…no**
11. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valve 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. 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. Allergies or sinus problems……yes….no
    d. Asthma or hay fever……yes….no
    e. Fainting spells or seizures……yes….no

f. Persistent diarrhea or recent weight loss……yes….no
g. Diabetes……yes….no
h. Hepatitis, jaundice or liver disease……yes….no
i. AIDS or HIV infection or sexually transmitted disease……yes….no
j. Thyroid problems……yes….no
k. Respiratory problems, emphysema, bronchitis, etc……yes….no
l. Arthritis or painful joints……yes….no
m. Stomach ulcer or hyperacidity……yes….no
n. Kidney trouble……yes….no
o. Tuberculosis……yes….no
p. Persistent cough or cough that produces blood……yes….no
q. Persistent swollen glands in neck……yes….no
r. Low blood pressure……yes….no
s. Epilepsy or other neurological disease……yes….no
t. Problems with mental health……yes….no
u. Cancer……yes….no
v. Problems of the immune system……yes….no

12. Have you ever had any artificial joint replacement procedures?……yes….no

13. Have you had abnormal bleeding?……yes….no
    a. Have you ever required a blood transfusion?……yes….no
14. Do you have any blood disorder such as anemia?……yes….no
15. Have you ever had any treatment for a tumor or growth?……yes….no
16. **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_____**
17. Have you had any serious trouble associated with any previous dental treatment?……yes….no
    If so, explain_____
18. Do you have any disease, condition, or problem not listed above that you think we should know about?
    _____
19. Are you wearing contact lenses?……yes….no
20. Are you wearing a removable dental appliance?……yes….no

Women Section Only

21. Are you pregnant?……yes….no
22. Do you have any problems associated with your period?……yes….no
23. Are you nursing?……yes….no
24. 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 answers, if any, about the inquiries set forth above have been answered to the best of my knowledge. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form

Signature: _____ Date:_____