

MEDICAL HISTORY FORM

Date _____

Name _____ Home Phone (____) _____
Last First Middle

Address _____ Cell/Business Phone (____) _____

City _____ State _____ Zip Code _____ Social Security No. _____

Employer _____ Occupation _____ Email _____

Date of Birth ____ / ____ / ____ Sex M F Height ____ Weight ____ Single Married Widowed

Name of Spouse _____ Closest Relative _____ Phone (____) _____

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

General Dentist _____ Referred By _____

For the following questions, please circle answer 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.

- 1. Are you in good health?..... Yes No
- 2. Has there been any change in you general health in the last year?Yes No
If yes, please explain _____
- 3. Your last physical examination was : _____
- 4. Are you now under the care of a physician?Yes No
If so, what is the condition being treated? _____
- 5. What is the name and address of your physician _____

- 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?.....Yes No
If so, what was the illness/condition? _____
- 7. Are you taking any medicine(s), including non-prescription medicine?.....Yes No
If so, what medication(s) are you taking? _____

- 8. Do you premedicate with antibiotics prior to dental procedures?..... Yes No

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

- 1. Damaged heart valves, artificial heart valves, heart murmurs, or rheumatic heart disease..... Yes No
- 2. Cardiovascular heart disease (high blood pressure, heart attack, stroke, angina, coronary insufficiency, coronary occlusion, arteriosclerosis)..... 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 defects?..... Yes No
Do you have a cardiac pacemaker?..... Yes No
- 3. Do you have any type of prosthesis (i.e., hip, knee, etc.)?..... Yes No
If yes, what type do you have? _____
- 4. Allergies (i.e., mold, dust, smoke, etc.)..... Yes No
- 5. Sinus Trouble..... Yes No
- 6. Asthma or hay fever..... Yes No
- 7. Fainting spells or seizures..... Yes No
- 8. Persistent diarrhea or recent weight loss..... Yes No
- 9. Diabetes..... Yes No

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|---|-----|----|
| 10. Hepatitis, jaundice, or liver disease..... | Yes | No |
| 11. AIDS or HIV infection..... | Yes | No |
| 12. Thyroid problems..... | Yes | No |
| 13. Respiratory problems, emphysema, bronchitis, etc..... | Yes | No |
| 14. Arthritis or painful swelling joints..... | Yes | No |
| 15. Stomach ulcer or hyperacidity..... | Yes | No |
| 16. Kidney trouble..... | Yes | No |
| 17. Tuberculosis..... | Yes | No |
| 18. Persistent cough or cough that produces blood..... | Yes | No |
| 19. Persistent swollen glands in the neck..... | Yes | No |
| 20. Low blood pressure..... | Yes | No |
| 21. Sexually transmitted disease..... | Yes | No |
| 22. Epilepsy or other neurological disease..... | Yes | No |
| 23. Problems with mental health..... | Yes | No |
| 24. Cancer..... | Yes | No |
| 25. Problems with the immune system..... | Yes | No |
| 26. Abnormal bleeding..... | Yes | No |
| 27. Have you ever required a blood transfusion?..... | Yes | No |
| 28. Do you have any blood disorder such as anemia?..... | Yes | No |
| 29. 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..... | Yes | No |
| Other antibiotics, if yes please list..... | 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 |
| Latex..... | Yes | No |
| Other _____ | Yes | No |

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|---|-----|----|
| 30. Have you had any serious trouble associated with previous dental treatment?..... | Yes | No |
| If so, please explain _____ | | |
| 31. Do you have any disease or condition not listed above that I should be aware of?..... | Yes | No |
| If yes, please explain _____ | | |
| 32. Are you wearing contact lenses?..... | Yes | No |
| 33. Are you wearing removable dental appliances?..... | Yes | No |
| 34. Do you have any dental implants?..... | Yes | No |
| 35. Do you smoke and/or use tobacco products?..... | Yes | No |
| Packs per day? _____ | | |
| 36. Did you ever smoke and/or use tobacco products?..... | Yes | No |
| If yes, when did you stop? _____ | | |

Women Only

- | | | |
|--|-----|----|
| 37. Are you pregnant?..... | Yes | No |
| 38. Do you have any trouble associated with your menstrual cycle?..... | Yes | No |
| 39. Are you nursing?..... | Yes | No |
| 40. Are you taking birth control pills?..... | Yes | No |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I am aware that I am responsible for my account, regardless of insurance coverage. I am also aware that I am responsible for any reasonable collection costs and/or attorney fee should my account become delinquent.

X _____
Signature of patient (parent, if minor)