MEDICAL HISTORY FORM

NAME _____ DATE_____ D.O.B. _____

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.

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 of my physician(s) is _____ Phone _____
6. 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? _____
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
   If so, what medicine(s) are you taking? _____
8. Are you a smoker? ..... Yes No
9. 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 or defibrillator? ..... Yes No
   c. Allergy ..... Yes No
   d. Sinus trouble ..... Yes No
   e. Asthma or hay fever ..... Yes No
   f. Fainting spells or seizures ..... Yes No
   g. Persistent diarrhea or recent weight loss ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice or liver disease ..... Yes No
   j. AIDS or HIV infection ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   m. Arthritis or painful swollen joints ..... Yes No
   n. Stomach ulcer or hyperacidity ..... Yes No
   o. Kidney trouble or dialysis ..... Yes No
   p. Tuberculosis ..... Yes No
   q. Persistent cough or cough that produces blood ..... Yes No
   r. Persistent swollen glands in neck ..... Yes No
   s. Low Blood pressure ..... Yes No
   t. Sexually transmitted disease ..... Yes No
   u. Epilepsy or other neurological disease ..... Yes No
   v. Problems with mental health ..... Yes No
   w. Cancer, radiation or chemotherapy ..... Yes No
   x. Problems of the immune system ..... Yes No
   y. HIV Positive ..... Yes No

10. Have you had abnormal bleeding or healing problems? ..... Yes No
    a. 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. Latex gloves or rubber products ..... Yes No
    i. Other _____
14. Have you ever had any serious trouble associated with any previous dental treatment? ..... Yes No
    If so, explain _____
15. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
    If so, explain _____
16. Are you wearing contact lenses? ..... Yes No
17. Are you wearing removable dental appliances? ..... Yes No
18. Do you have or ever been tested for sleep apnea? ..... Yes No

Women

19. Are you pregnant? ..... Yes No
20. Do you have any problems associated with your menstrual period? ..... Yes No
21. Are you nursing? ..... Yes No
22. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint, (if any): _____

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

Signature of Person Completing Form _____

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.

Signature	Date	Dr. Initials	Date
Signature	Date	Dr. Initials	Date
Signature	Date	Dr. Initials	Date
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