MEDICAL HISTORY FORM

Name: _____ Date: _____

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 health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is: _____
   _____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills ..... Yes No
   If so, please list _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Rheumatic Heart Disease ..... Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
      1. Chest pain upon exertion? ..... Yes No
      2. Shortness of breath after mild exercise? ..... Yes No
      3. Do your ankles swell? ..... Yes No
      4. Do you need to be **PRE-MEDICATED BEFORE ANY SURGERIES (ANY HEALTH CONDITION**)? Yes No
   d. Allergies ..... Yes No
   e. Sinus trouble ..... Yes No
   f. Asthma or hay fever ..... Yes No
   g. Fainting spells or seizures ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice or liver disease ..... Yes No
   j. Frequent or recurring mouth sores ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
   n. Stomach ulcer or hyperacidity ..... Yes No
   o. Kidney trouble ..... Yes No
   p. Tuberculosis ..... Yes No
   q. Persistent cough or cough that produces blood ..... Yes No
   r. Persistent swollen neck glands ..... Yes No
   s. Low blood pressure ..... Yes No
   t. Epilepsy or neurological disorder ..... Yes No
   u. Are you taking vitamins or homeopathic remedies ..... Yes No
   v. Cancer ..... Yes No
   w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
9. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you ever had treatment for a tumor or growth? ..... Yes No
12. Do You SMOKE? ..... Yes No
13. Are you allergic to or have you had a reaction to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Barbiturates or sleeping pills ..... Yes No
   e. Aspirin ..... Yes No
   f. Iodine ..... Yes No
   g. Codeine or other narcotics ..... Yes No

h. Other-METAL ALLERGIES? ..... Yes No

14. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
15. Do you have any other condition or disease you think the doctor 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 wish to talk with the doctor privately about anything? ..... Yes No

Women

19. Are you pregnant or trying to become pregnant ..... Yes No
20. Do you have 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: _____

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 the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient's Signature: _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Date: _____ Doctor's Signature: _____

Medical History Update:

Date	Comments	Signature