

# Medical History Form

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date of Birth    |    |    Sex M F Height \_\_\_\_\_ Weight \_\_\_\_\_  Single  Married  
mo day yr

Name of Spouse \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

How would you like to be addressed? \_\_\_\_\_ How did you find out about our office? \_\_\_\_\_

Email address \_\_\_\_\_

**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.**

- Yes No 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 \_\_\_\_\_
- Yes No 4. Are you now under the care of a physician?  
If so, what condition is being treated? \_\_\_\_\_
- Yes No 5. The name and phone number of my physician (s) is (are): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Yes No 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?  
If so, what was the illness or problem? \_\_\_\_\_
- Yes No 7. Are you taking any medicine(s) including non-prescription medicine?  
If so, what medicine are you taking? \_\_\_\_\_
- Yes No a. Do you take any illegal controlled substance/drugs?
- Yes No 8. Do you have any allergies?
- Yes No 9. Are you allergic or have you had a reaction to:  
Yes No 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
- Yes No 10. My last dental examination was on \_\_\_\_\_
- Yes No 11. Have you ever taken a prescription diet medication called phen-fen?
- Yes No 12. Are you required to take prophylactic antibiotics prior to dental treatments?  
a. If yes, for what? \_\_\_\_\_
- Yes No 13. Do you have surgically placed artificial joints or other materials?  
a. When were they placed? \_\_\_\_\_
- Yes No 14. Do you have or have you had any of the following diseases or problems:  
Yes No 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 high or low blood pressure?  
Yes No 2. Do you have chest pain upon exertion?  
Yes No 3. Are you ever short of breath after mild exercise or when lying down?  
Yes No 4. Do your ankles swell?  
Yes No 5. Do you have inborn heart defects?  
Yes No 6. Do you have a cardiac pacemaker?  
Yes No 7. Do you have a cardiac defibrillator?  
Yes No c. Do you smoke, use chewing tobacco or vape?  
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. Thyroid problems  
Yes No k. Respiratory problems, emphysema, bronchitis, etc.  
Yes No l. Arthritis or painful swollen joints

