Medical History Form

Date ____________________

Name ______________________________________ Home Phone (____) ______________
Last First Middle

Address ______________________________________ Business Phone (____) ______________
Number, Street

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 referred to? ______________________________

How did you find out about our office? ______________________________

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 address 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(s) are you taking? ______________
Yes No **a.** Do you take any illegal controlled substance/drugs?
Yes No **8.** My last dental examination was on ______________
Yes No **9.** Have you ever taken a prescription diet medication called phen-fen?
Yes No **10.** Do you routinely take prophylactic antibiotics prior to dental treatments?
11. 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 **12.** Do you have surgically placed artificial joints or other materials?
Yes No **c.** Do you smoke or use chewing tobacco?
Yes No **d.** Allergy
Yes No **e.** Sinus trouble
Yes No **f.** Asthma or hay fever
Yes No **g.** Fainting spells or seizures
Yes No **h.** Persistent diarrhea or recent weight loss
Yes No **i.** Diabetes
Yes No **j.** Hepatitis, jaundice or liver disease
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
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.** Sexually transmitted disease
Yes No **t.** Epilepsy or other neurological disease
Yes No **u.** Problems with mental health
Yes No **v.** Cancer
Yes No **w.** Problems of the immune system/including AIDS or HIV infection

Over

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?
16. 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 **17.** Have you had any serious trouble associated with any previous dental treatment?
If so, explain ______________________________
____

Yes No **18.** Do you have any disease, condition, or problem not listed above that you think I should know about?
If so, explain ______________________________
____

Yes No **19.** Are you wearing contact lenses?
Yes No **20.** Are you wearing removable dental appliances?
Yes No **21.** Do you have headaches and or pain in or near your ears or jaw joint?
Yes No **22.** Do you have a clicking jaw joint or other joint noise?
Yes No **23.** Do you have any loose or sensitive teeth?
Yes No **24.** Do your gums bleed?

Women:
Yes No **25.** Are you pregnant?
Yes No **26.** Are you nursing?
Yes No **27.** Are you taking birth control pills?

Chief Dental Complaint ______________________________
____

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

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. I authorize my x-rays to be transferred upon request. I understand that a 1 ½% finance charge (18% annual) will be added to any balance over 60 days.

______________________________ ______________________________
Signature of Doctor Signature of Patient

Medical History Update:

Date	Comments	Sign

Blood Pressure:

Date	