

# Medical History Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Closest Relative: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

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

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.

## PLEASE CIRCLE YES OR NO.

1. Yes No ..... Are you in good health?
2. Yes No ..... Has there been any change in your general health within the past year?
3. My last physical examination was on \_\_\_\_\_
4. Yes No ..... Are you under the care of a physician?  
It so, what is the condition being treated? \_\_\_\_\_
5. The name and address of my physician(s) is \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Yes No ..... Have you had any serious illness, operations, or been hospitalized in the past 5 yrs?  
If so, what? \_\_\_\_\_
7. Yes No ..... Are you taking any medicine(s) including non-prescription medicine and/or "street drugs"?  
If so, what medicine(s) are you taking? \_\_\_\_\_
8. 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 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 birth defects?  
Yes No ..... 5. Do you have a cardiac pacemaker?  
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 unexplained 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 ..... i. 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. 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  
Yes No ..... x. Problems with immune systems  
Yes No ..... y. Night sweats or increased temperature of unknown origin
9. Yes No ..... Have you had abnormal bleeding?  
Yes No ..... a. Have you ever required a blood transfusion?
10. Yes No ..... Do you have any blood disorder such as anemia?
11. Yes No ..... Have you ever had any treatment for a tumor or growth?

12. Are you allergic or have you had a reaction to : (Circle the appropriate ones) '

- a. Local anesthetics
- b. Penicillin or other antibiotics
- c. Sulfa drugs
- d. Barbituates, sedatives, or sleeping pills
- e. Aspirin
- f. Iodine
- g. Codeine or other narcotics
- h. Other \_\_\_\_\_

13. Have you ever had any serious trouble associated with any previous dental treatment? \_\_\_\_\_

14. Do you have any disease, condition, or problem not listed above that you think I should know about? \_\_\_\_\_

15. Are you wearing contact lenses?

16. Are you wearing removable dental appliances?

**Women**

17. Are you pregnant?

18. Do you have any problems associated with your menstrual period?

19. Are you nursing?

20. Are you taking birth control pills?

**Chief Dental Complaint** \_\_\_\_\_  
\_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the Inquires 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 of Patient

\_\_\_\_\_  
Signature of Dentist

**For completion by the dentist.**

Comments on patient interview concerning medical history:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History Update**

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____