Medical History

Date_____

Name_____Address_____
Last First Middle

City_____State____Zip Code_____Home Phone_____Work Phone_____

Date of Birth_____Sex___Height_____Weight_____ Cell Phone_____

Soc. Sec. No._____Single____Married____Name of Spouse_____

Email address:_____Do you want text message appointment reminders?_____

Referred by_____Your Occupation_____

Closest Relative_____Phone_____

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

Please circle yes or no. Your answers are for our records only and will be considered confidential.

Yes No Are you in good health?
Yes No Has there been any change in your general health within the past year?
Yes No Are you now under the care of a physician?
If so, what is the condition being treated?_____

My last physical examination was on_____

The name and address of my physician is_____

Yes No Have you had any serious illness or operation?
If so, what was the illness or operation?_____

Yes No Have you been hospitalized in the past five years?
If so, what was the problem?_____

Do you have or have you had any of the following diseases or problems?

Yes No Damaged heart valves or artificial heart valves, including a heart murmur
Yes No Congenital heart lesions
Yes No Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
Yes No Do you have chest pain upon exertion or are you ever short of breath after mild exercise?
Yes No Do your ankles swell, get short of breath when you lie down or require extra pillows when you sleep?
Yes No Do you have a cardiac pacemaker?
Yes No Allergies, sinus trouble
Yes No Asthma or hay fever
Yes No Hives or a skin rash
Yes No Fainting spells, seizures, or epilepsy
Yes No Diabetes
Yes No Do you have to urinate (pass water) more than six times a day?
Yes No Are you thirsty much of the time or does your mouth frequently become dry?
Yes No Hepatitis, jaundice or liver disease
Yes No Arthritis or inflammatory rheumatism (painful swollen joints)
Yes No Stomach ulcers
Yes No Kidney trouble
Yes No Tuberculosis
Yes No Do you have a persistent cough or cough up blood?
Yes No Low blood pressure
Yes No Venereal disease
Yes No Psychiatric problems
Yes No Cancer
Yes No AIDS, HIV or other immunosuppressive disorders
Yes No Other_____

(over)

Yes No Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
Yes No Do you bruise easily?
Yes No Have you ever required a transfusion?
If so, explain the circumstances_____
Yes No Do you have any blood disorder such as anemia?
Yes No Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of the head or neck?

Are you taking any of the following (please include names of all medications):

Yes No Antibiotics
Yes No Anticoagulants (blood thinners)
Yes No Medicine for high blood pressure
Yes No Cortisone (steroids)
Yes No Tranquilizers or anti-depressants
Yes No Antihistamines
Yes No Aspirin
Yes No Insulin or other blood sugar control medicine
Yes No Digitalis or medicine for heart trouble
Yes No Nitroglycerin
Yes No Oral contraceptive or hormonal therapy
Yes No **Please list all other medications**_____

Are you allergic or have you reacted adversely to:

Yes No Local anesthetics (such as Novacaine)
Yes No Penicillin or other antibiotics
Yes No Sulfa drugs
Yes No Barbiturates, sedatives, or sleeping pills
Yes No Aspirin
Yes No Iodine
Yes No Codeine or other narcotics
Yes No Latex (including gloves)
Yes No Other_____

Yes No Have you had any serious trouble associated with any previous dental treatment?
If so, explain_____
Yes No Do you have any disease, condition, or problem not listed above that you think I should know about?
If so, explain_____
Yes No Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?
Yes No Are you wearing contact lenses?
Yes No Do you smoke? How much and for how long?_____

Yes No Do you need to take antibiotics (premedicate) prior to dental treatment?

Women

Yes No Are you pregnant?
Yes No Do you have any problems associated with your menstrual period?
Yes No Are you nursing?

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 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_____