

MEDICAL HISTORY FORM

DATE: _____

Name: _____

Home Phone: (____) _____

Address: _____

Cell Phone: (____) _____

City: _____ St: _____ Zip: _____

Business Phone: (____) _____

Date of Birth: ___/___/___ Sex: M F Weight: _____ Height: _____ Social Security #: _____

Single Married Divorced Widowed Name Spouse / Parent: _____

Your Email: _____ Whom may we thank for referring you to our office? _____

Self: _____

| Employer | Address | Phone | Position | How Long |
|----------|---------|-------|----------|----------|
|----------|---------|-------|----------|----------|

Spouse: _____

| Name of Company | Address | Phone | Position | How Long |
|-----------------|---------|-------|----------|----------|
|-----------------|---------|-------|----------|----------|

Closest Relative _____ Relationship: _____ Phone: _____
(Someone who does not live with you)

Medical Doctor: _____

Phone No. _____ Last Exam _____

Pharmacy: _____ Phone No: _____

Are you in good health? Yes No

If you are under the care of a physician, please explain _____

Are you wearing contact lenses? Yes No

Are you wearing removable dental appliances? Yes No

Are you taking any medicine, including non-prescription? Yes No

If so, what are they: _____

Do you take aspirin regularly? Yes No

Chief Dental Complaint: _____

Have you had any serious trouble with previous dental treatment? Yes No If yes, please explain: _____

Doctor's Notes: _____

Continued on back

Do you have, or have you had any of the following diseases or problems? (circle your responses)

- Yes No Damaged heart valves or artificial heart valves, including heart murmur, mitral-valve prolapse or rheumatic heart disease.
- Yes No Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke, congestive heart failure).
- Yes No High Blood Pressure
- Yes No Low Blood Pressure
- Yes No Chest pain upon exertion.
- Yes No Short of breath after mild exercise or when lying down.
- Yes No Ankles that swell.
- Yes No Inborn heart defects
- Yes No Cardiac pacemaker
- Yes No Hay fever or seasonal Allergies
- Yes No Sinus trouble
- Yes No Asthma
- Yes No Persistent diarrhea or recent weight loss
- Yes No Diabetes Type I Type II
- Yes No Hepatitis, jaundice, or liver disease
- Yes No AIDS or HIV infection
- Yes No Sexually transmitted disease
- Yes No Thyroid problems
- Yes No Respiratory problems, emphysema, bronchitis, etc.
- Yes No Arthritis or painful swollen joints
- Yes No Stomach ulcer or hyperacidity
- Yes No Kidney trouble
- Yes No Tuberculosis
- Yes No Persistent cough or cough that produces blood
- Yes No Persistent swollen glands in neck
- Yes No Fainting spells or seizures
- Yes No Epilepsy or other neurological disease
- Yes No Problems with mental health
- Yes No Cancer
- Yes No Problems of the immune system
- Yes No Abnormal bleeding
- Yes No Blood transfusion
- Yes No Blood disorder, including anemia
- Yes No Tumor or growth
- Yes No Other: _____

Have you had an allergic reaction to any of the following: (circle your response)

- Yes No Local anesthetics
- 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
- Yes No Other: _____

Has there been any change in your general health within the past year? Yes No If so please explain: _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No If so please explain: _____

Please list any disease, conditions, or problems not listed that you think we should know about? _____

For Women Only:

- Are you pregnant? Yes No
- Are you nursing? Yes No
- Do you have any problems with your menstrual period? Yes No
- Are you taking birth control pills? Yes No

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

Date

Medical History Update:

Date/Initials _____

Date/Initials _____

Date/Initials _____

Date/Initials _____

Date/Initials _____