

Medical History Form

Name _____ Home Phone () _____
Last First Middle

Address _____ Business Phone () _____

City _____ State _____ Zip Code _____

E-mail Address _____ Occupation _____ Social Security _____

Date of Birth ___/___/___ Sex M/F Height _____ Weight _____ Single _____ Married _____

Insurance Carrier: _____ Group Number: _____ Relationship to insured? _____

Member's Name: _____ Member's Social Security: _____

Member's Employer: _____ Member's Date of Birth: _____

Name of Spouse _____ Closest Relative _____ Phone () _____

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

Referred by _____

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.

1. Are you in good health?..... Yes No
2. Has there been any changes in your general health within the past year?..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician?..... Yes No
If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? Yes No
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. Damage 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 heart 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 recent 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 |
| 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. 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 of the immune system | Yes | No |
| 9. Have you had abnormal bleeding..... | Yes | No |
| a. Have you ever required a blood transfusion? | Yes | No |
| 10. Do you have any blood disorder such as anemia? | Yes | No |
| 11. Have you ever had any treatment for a tumor or growth? | Yes | No |
| 12. Are you allergic or have you had a reaction to: | | |
| 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 |
| 13. Have you had any serious trouble associated with any previous dental treatment?..... | Yes | No |
| If so, explain _____ | | |
| 14. Do you have any disease, condition, or problem not listed above that you think I should know about? If so, explain _____ | | |
| 15. Are you wearing contact lenses?..... | Yes | No |
| 16. Are you wearing removable dental appliances?..... | Yes | No |

Women

- | | | |
|--|-----|----|
| 17. Are you pregnant? | Yes | No |
| 18. Do you have any problems associated with your menstrual period?..... | Yes | No |
| 19. Are you nursing? | Yes | No |
| 20. Are you taking birth control pills? | Yes | No |

Chief Dental Complaint /Concerns: _____

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 or Legal Guardian

Date: _____