MEDICAL HISTORY

Date:______________________

Name: ____ Date of Birth:_______________________ Sex: M F

Address:____ Height:__ft.__in. Weight:______lbs.

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 you may 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 change 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**

5. If so, what is the condition being treated?____

6. The name, address and phone # of my physician(s) is/are:_____________________________________
____
____

7. Have you had any serious illness, operation, or been hospitalized in the past? . . . . **YES NO**
   If so, what was the illness or problem?____
   ____

8. Are you taking any medication(s) including non-prescription medicine? . . . . **YES NO**
   If so, what medication(s) are you taking?____
   ____
   ____

9. Have you taken any cortisone or steroid medication in the last two years? . . . . **YES NO**

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

- **YES** **NO…..** Damaged heart valves or artificial heart valves, heart murmur or rheumatic heart disease?
- **YES** **NO…..** Cardiovascular disease such as: heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, congenital heart disease?
- **YES** **NO…..** Do you have chest pain upon exertion?
- **YES** **NO…..** Are you ever short of breath after mild exercise or when lying down?
- **YES** **NO…..** Do your ankles swell?
- **YES** **NO…..** Do you have inborn heart defects?
- **YES** **NO…..** Do you have a cardiac pacemaker?
- **YES** **NO…..** Low blood pressure?
- **YES** **NO…..** Have you had abnormal bleeding?
- **YES** **NO…..** Have you ever required a blood transfusion?
- **YES** **NO…..** Any blood disorder such as anemia?
- **YES** **NO…..** Fainting spells or seizures?
- **YES** **NO…..** Epilepsy or other neurological disease?
- **YES** **NO…..** Problems with mental health?
- **YES** **NO…..** Diabetes or trouble with sugar?
- **YES** **NO…..** Hepatitis, jaundice or liver disease?
- **YES** **NO…..** Thyroid or adrenal problems?
- **YES** **NO…..** Kidney trouble or dialysis?
- **YES** **NO…..** Allergies?
- **YES** **NO…..** Sinus trouble?
- **YES** **NO…..** Asthma?
- **YES** **NO…..** AIDS or HIV infection?
- **YES** **NO…..** Respiratory problems, emphysema, bronchitis, etc.?
- **YES** **NO…..** Tuberculosis
- **YES** **NO…..** Persistent cough or cough that produces blood?

- **YES** **NO…..** Sexually transmitted disease?
- **YES** **NO…..** Problems of the immune system?
- **YES** **NO…..** Persistent diarrhea or recent weight loss?
- **YES** **NO…..** Gastrointestinal Disorders?
- **YES** **NO…..** Stomach ulcer or hyperacidity?
- **YES** **NO…..** Cancer, chemotherapy, or radiation therapy?
- **YES** **NO…..** Have you ever had any treatment for a tumor or growth?
- **YES** **NO…..** Persistent swollen glands in neck?
- **YES** **NO…..** Arthritis or painful, swollen joints?
- **YES** **NO…..** Are you wearing contact lenses?
- **YES** **NO…..** Are you wearing removable dental appliances?
- **YES** **NO…..** Do you smoke or chew tobacco?
- **YES** **NO…..** Do you drink alcohol every day or every other day?

Are you allergic or have you had a reaction to:

- **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

***<u>Women</u>*:**

- **YES** **NO…**.. Are you pregnant?
- **YES** **NO…..** Do you have any problems associated with your menstrual period?
- **YES** **NO…..** Are you nursing?
- **YES** **NO…..** Are you taking birth control pills?

11. Do you have any disease, condition, or problem not listed that you think I should know about? **YES** **NO**
If so, please explain:____

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 staff responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of Patient (or Parent/Guardian if minor)

<u>FOR COMPLETION BY THE DENTIST</u>

Significant findings from questionnaire or oral interview:____________________________

Dental Management considerations:____________________________________

Date ____________________ Signature of Dentist ____________________

<u>Medical History update:</u>

<u>Date</u>	<u>Comments</u>	<u>Initials</u>