# Medical History Form

Date _____

Patient's Name _____ _____
Last First Middle Initial Date of Birth

*For the following, circle the appropriate answer. If you don't know the correct answer - please write "DK" for don't know on the line after the question.*

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 exam was _____
4. Are you under the care of a physician ..... Yes No
   If so, what is the condition being treated _____
   _____
5. My physician's name, address and phone number 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?
   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 heart defects? ..... Yes No
      5. Do you have a 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

**COMMENTS**

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) Epilepsy or other neurological disease? ..... Yes No
u) Problems with mental health? ..... Yes No
v) Sexually transmitted diseases? ..... 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 a 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 to 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. Any metals? ..... Yes No
    i. Latex? ..... Yes No
    j. Other?_____ Yes No
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
    If yes, explain _____
    _____
14. Do you have any disease, condition or problem not listed above that you think we should know about ..... Yes No
    If yes, explain _____
    _____
15. Are you wearing removable dental appliances? ..... Yes No
16. Do you smoke, chew, use snuff or any other forms of tobacco? ..... Yes No
17. Do you have problems with snoring or sleep apnea? ..... Yes No

**COMMENTS**

I certify that the above information is complete and accurate. I acknowledge that any questions I have had about this form have been answered to my satisfaction.

_____
Signature of Patient/Guardian

## MEDICAL HISTORY UPDATES

| Date | Comments | Signature |
|---|---|---|
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