MEDICAL HISTORY FORM

Date: _____

Cell Phone: ( ) _____

E-Mail Address: _____

Name _____ Home Phone: ( ) _____

Last First Middle

Business Phone: ( ) _____

Address _____

City _____ State _____ Zip Code _____

Occupation/School _____ Social Security No. _____

Date of Birth ____/____/____ Sex M F Driver's License No. Are you a student? Yes No
Mo. Day Year

Name of Spouse _____ Emergency Information: Name and address of closest relative not living with you:

_____

_____ Phone ( ) _____

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

Referred by _____ Person responsible for account _____

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 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. The name and address of my physician(s) is:

   _____

   _____

   Phone: ( ) _____
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 medicines(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. 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? .....
      2. Are you ever short of breath after mild exercise or when laying 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, Hives, Skin Rash ..... Yes No
   d. Asthma, Hay Fever, Sinus Trouble ..... Yes No
   e. Glaucoma ..... 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 or lung disease ..... Yes No
q. Persistent cough or cough that produces blood ..... Yes No
r. Persistent swollen glands in the neck ..... Yes No
s. Low blood pressure ..... Yes No
t. Sexually transmitted disease (venereal disease, herpes) ..... 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
y. Artificial joints (hip, knee) ..... Yes No
z. Alcoholism or drug addiction ..... Yes No

9. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
   b. Do you bruise easily? ..... 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. Nitrous oxide ..... Yes No
   c. Penicillin or other antibiotics ..... Yes No
   d. Sulfa drugs ..... Yes No
   e. Barbiturates, sedatives or sleeping pills ..... Yes No
   f. Aspirin ..... Yes No
   g. Iodine ..... Yes No
   h. Codeine or other narcotics ..... Yes No
   i. Valium ..... Yes No
   j. 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 disease, condition or problem not listed above that you think I should know about? ..... Yes No
   If so, explain _____
15. Are you wearing contact lenses? ..... Yes No
16. Are you wearing removable dental appliances? ..... Yes No
17. Do you smoke? ..... Yes No
18. Do you chew tobacco? ..... Yes No

Women

19. Are you pregnant? ..... Yes No
20. Do you have any problems associated with your menstrual period? ..... Yes No
21. Are you nursing? ..... Yes No
22. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint?

_____

_____

_____

Date of your last dental visit _____

Date of your last full mouth x-rays _____
(Panorex – Machine that rotates around your head; or full mouth series = 14-18 small x-ray films)

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 (If minor, signature of parent or guardian)