MEDICAL HISTORY FORM

Date .....

Name ..... Home Phone ( ) .....

Address ..... Business Phone ( ) .....

City ..... State ..... Zip Code ..... Cell Phone ( ) .....

Email ..... Preferred contact number .....

Occupation ..... Social Security Number .....

Date of Birth ...../...../..... Sex Ⓜ Ⓕ Height ..... Weight ..... Single ◯ Married ◯

Name of Spouse .....

Closest Relative ..... Phone ( ) .....

Referred by .....

For the following questions, check 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 ☐

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

5. The name and phone # 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?

   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 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 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 anesthetic's 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. Lodine 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, please explain .....
   .....
   .....

14. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes ☐ No ☐

   If so, please explain .....
   .....
   .....

15. Are you wearing contact lenses? Yes ☐ No ☐

16. Are you wearing removable dental appliances? Yes ☐ No ☐

Women

18. Are you pregnant? Yes ☐ No ☐

19. Do you have any problems associated with your menstrual period? Yes ☐ No ☐

20. Are you nursing? Yes ☐ No ☐

21. Are you taking birth control pills? Yes ☐ No ☐

Tobacco Use

22. Do you smoke? Yes ☐ No ☐

   If so, please elaborate .....
   .....
   .....

For Completion by the dentist

Comments on patient interview concerning medical history: .....

.....

.....

Significant findings from questionnaire or oral interview: .....

.....

.....

Dental management considerations: .....

.....

.....

Date: ..... Signature of Dentist: .....

Medical History Update:

Date: .....

Comments: .....

.....

.....

Signature: .....

Date: .....

Comments: .....

.....

.....

Signature: .....