MEDICAL HISTORY FORM

Name: _____ Date: _____

Name you preferred to be called _____

Date of Birth: _____ Sex: M / F

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is: _____
   _____
   _____
6. Have you had any serious illness, significant operation or hospitalization within the past 5 years? ..... Yes No
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills ..... Yes No
   If so, please list _____
   _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Rheumatic Heart Disease ..... Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
      1. Chest pain upon exertion? ..... Yes No
      2. Shortness of breath after mild exercise? ..... Yes No
      3. Do your ankles swell? ..... Yes No
   d. Allergies ..... Yes No
   e. Sinus trouble ..... Yes No
   f. Asthma or hay fever ..... Yes No
   g. Fainting spells or seizures ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice or liver disease ..... Yes No
   j. Frequent or recurring mouth sores ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... 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 neck glands ..... Yes No
   s. Low blood pressure ..... Yes No
   t. Epilepsy or neurological disorder ..... Yes No
   u. Are you taking vitamins or homeopathic remedies ..... Yes No
   v. Cancer ..... Yes No
   w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
   x. HIV pos/AIDS ..... Yes No
   y. Artificial Joints (hip, knee) ..... 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 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 antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No

e. Aspirin
f. Iodine .... Yes No
g. Codeine or other narcotics .... Yes No
h. Latex or rubber products .... Yes No
i. Other .... Yes No

13. Have you had any serious trouble associated with previous dental treatment? .... Yes No
If so, explain: ______ Yes No
______

14. Do you have any other condition or disease you think the doctor should know about? .... Yes No
If so, explain: ______

15. Are you wearing contact lenses? ....
16. Are you wearing removable dental appliances? .... Yes No
17. Do you smoke .... Yes No
18. How long has it been since your last cleaning? ______ Yes No

Chief Dental Complaint: ______

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

Date: ______ Patient's Signature: ______

Medical History Update:

Date	Comments and Blood Pressure	Signature