Medical History Form

Date _____

Name _____ Home Phone ( )_____
Last First Middle

Business Phone ( )_____

Address_____ Cell Phone ( ) _____
Number, Street

Email: _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth ___/____/___ Sex M F Height _____ Weight _____ Single _____ Married _____
mo. day yr.

Name of Spouse _____ Closest Relative _____ Phone ( ) _____

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

Referred by _____

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 now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
2. The name of your physician(s) is _____
3. Have you had any serious illness, operation, or been hospitalized in the past five years? ..... Yes No
   If so, what was the illness or problem? _____
4. Are you taking any medicine(s) including nonprescription medicine? ..... Yes No
   If so, what medicine(s) are you taking? _____
   _____
5. Do you have or have you had any of the following diseases or problems? .....
   a. Damaged heart valves, artificial heart valves, heart murmur? ..... 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 you have inborn heart defects? ..... Yes No
      4. Do you have a cardiac pacemaker? ..... Yes No
      5. Do you have irregular heart rhythm? ..... Yes No
   c. Sinus trouble ..... Yes No
   d. Asthma ..... Yes No
   e. Fainting spells or seizures ..... Yes No
   f. Diabetes ..... Yes No
   g. Hepatitis, jaundice or liver disease ..... Yes No
   h AIDS or HIV infection ..... Yes No
   i. Thyroid problems ..... Yes No
   j. Respiratory problems, bronchitis, etc. ..... Yes No
   k. Arthritis or painful swollen joints ..... Yes No
   l. Stomach ulcer or hyperacidity ..... Yes No
   m. Kidney trouble ..... Yes No
   n. Tuberculosis ..... Yes No
   o. Persistent swollen glands in neck ..... Yes No
   p. Sexually transmitted disease ..... Yes No
   q. Epilepsy or other neurological disease ..... Yes No
   r. Problems with mental health ..... Yes No
   s. Cancer ..... Yes No
   t. Problems of the immune system ..... Yes No
   u. Artificial joints ..... Yes No
6. Have you ever taken medicines other than calcium for osteoporosis? ..... Yes No

7. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
8. Do you have any blood disorder such as anemia? ..... Yes No
9. Have you ever had treatment for a tumor or growth? ..... Yes No
10. Are you allergic or have you had a reaction to: .....
   a. Local anesthetic ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Latex ..... Yes No
   e. Aspirin or NSAIDS ..... Yes No
   f. Iodine ..... Yes No
   g. Codeine or other narcotics ..... Yes No
   h. Other _____
11. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
   If so, explain _____
12. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
   If so, explain _____
13. Do you use tobacco? ..... Yes No

Women

14. Are you pregnant? ..... Yes No
15. Are you nursing? ..... Yes No

Chief DENTAL complaint _____

_____

_____

Signature of Patient

For completion by the dentist.

_____

_____

_____

_____

_____

_____

_____

_____ _____

(Date) Signature of Dentist

Medical history update:

Date	Comments	Initials
_____	_____	_____
_____	_____	_____
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