Medical History Form

Date_____

Name_____ Email _____
Last First Middle

Home #(_____)_____ Cell #(_____)_____ Work #(_____)_____

Address_____ Pharmacy #(_____)_____
Number, Street

City_____ State_____ Zip Code_____

Date of Birth_____/_____/_____ Sex ❑ M ❑ F Height_____ Weight_____
month day year

Occupation_____ ❑ Single ❑ Married

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 in good health? ❑Yes ❑No
2. Have there been any changes 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 address of my physician(s) is _____
   _____
   _____
6. Have you had any serious illnesses, operations, 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
      i. Do you have chest pain upon exertion? ❑Yes ❑No
      ii. Do you have inborn heart defects? ❑Yes ❑No
      iii. 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. Diabetes ❑Yes ❑No
   h. Hepatitis, Jaundice, or Liver Disease ❑Yes ❑No
   i. AIDS or HIV Infection ❑Yes ❑No
   j. Thyroid Problems ❑Yes ❑No
   k. Respiratory Problems, Emphysema, Bronchitis, etc. ❑Yes ❑No
   l. Arthritis or Painful Swollen Joints ❑Yes ❑No
   m. Stomach Ulcer or Hyperacidity ❑Yes ❑No
   n. Kidney Trouble ❑Yes ❑No

o. Tuberculosis ❑Yes ❑No
p. Low Blood Pressure ❑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

9. Have you had abnormal bleeding? ❑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. Penicillin or Other Antibiotics ❑Yes ❑No
    c. Latex ❑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. 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 any disease, condition, or problem not listed above that we should know about? ❑Yes ❑No
    If so, explain _____
    _____

Women

15. Are you pregnant? ❑Yes ❑No
16. Do you have any problems associated with your menstrual period? ❑Yes ❑No
17. Are you nursing? ❑Yes ❑No
18. Are you taking birth control pill? ❑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 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

For completion by the dentist

Comments or patient interview concerning medical history:

_____

_____

_____

Date_____ Signature of Dentist_____