

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. Do you smoke? Yes No
If so, how often? _____
10. Have you had abnormal bleeding? Yes No
11. Do you have any blood disorder such as anemia? Yes No
12. Have you ever had any treatment for a tumor or growth? Yes No
13. 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
14. Have you had any serious trouble associated with any previous dental treatment? Yes No
If so, explain _____
15. Do you have any disease, condition, or problem not listed above that we should know about? Yes No
If so, explain _____

Women

- 16. Are you pregnant? Yes No
- 17. Do you have any problems associated with your menstrual period? Yes No
- 18. Are you nursing? Yes No
- 19. 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. I acknowledge the existence of Wellesley Endodontics' HIPPA Notice of Privacy Practices.

Signature of Patient

For completion by the dentist

Comments or patient interview concerning medical history:

Date _____

Signature of Dentist _____