

Medical History Form

Name _____ Date _____
Last First Middle

Date of Birth / / Height _____ Weight _____
mo. day yr.

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

For the following questions, **circle 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. The name, address and phone number of my physician(s) is _____		
2. Are you in good health?	Yes	No
3. Has there been any change in your general health within the past year?	Yes	No
4. My last physical examination was on: _____		
5. Are you now under the care of a physician? If so, what is the condition being treated?	Yes	No
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem?	Yes	No
7. Are you taking any medication(s) including non-prescription medicine? If so, what medicine(s) are you taking?	Yes	No
8. Do you have or have you had any of the following diseases or problems?	Yes	No
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
6. Do you use tobacco in any form? If yes, how much?	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. Do you have any hip, knee, or other joint replacements?	Yes	No
o. Stomach ulcer or hyperacidity	Yes	No
p. Kidney trouble	Yes	No
q. Tuberculosis	Yes	No
r. Persistent cough or cough that produces blood	Yes	No
s. Persistent swollen glands in neck	Yes	No
t. Low blood pressure	Yes	No
u. Sexually transmitted disease	Yes	No
v. Epilepsy or other neurological disease	Yes	No
w. Problems with mental health	Yes	No
x. Cancer	Yes	No
y. 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

(OVER)

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 (if other, list name(s))	Yes	No
c. Sulfa drugs	Yes	No
d. Barbituates, sedatives, or sleeping pills	Yes	No
e. Aspirin	Yes	No
f. Iodine	Yes	No
g. Codeine or other narcotics	Yes	No
h. Latex	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 you think I should know about?	Yes	No
If so, explain		
15. Are you wearing contact lenses?	Yes	No
16. Are you wearing removable dental appliances?	Yes	No
Women		
17. Are you pregnant?	Yes	No
18. Are you nursing?	Yes	No
19. Are you taking birth control pills?	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 (or Parent/Legal Guardian)

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____