MEDICAL HISTORY FORM **Date**_____

Name_____ **Home Phone (____)** _____
Last First Middle

Address_____ **Cell/Business Phone (____)** _____

City _____ **State** _____**Zip Code** _____ **Social Security No.** _____

Employer _____ **Occupation** _____**Email**_____

Date of Birth ____ / _____ / _____ **Sex M F Height** _____ **Weight** _____ **Single Married Widowed**

Name of Spouse _____ **Closest Relative** _____ **Phone (___)**_____

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

General Dentist _____**Referred By**_____

For the following questions, please circle answer 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. **Are you in good health?**……**Yes No**
2. **Has there been any change in you general health in the last year?** ……..**Yes No**
   If yes, please explain_____
3. **Your last physical examination was :**_____
4. **Are you now under the care of a physician?** ……..**Yes No**
   If so, what is the condition being treated?_____
5. **What is the name and address of your physician** _____
   _____
   _____
6. **Have you had any serious illness, operation, or been hospitalized in the past 5 years?**…….**Yes No**
   If so, what was the illness/condition?_____
7. **Are you taking any medicine(s), including non-prescription medicine?**…….…….**Yes No**
   If so, what medication(s) are you taking?_____
   _____
8. **Do you premedicate with antibiotics prior to dental procedures?**…….. **Yes No**
9. **Are you currently taking a blood thinner other than Aspirin?**.....**Yes No**

Do you have or have you had any of the following diseases or conditions?

1. **Damaged heart valves, artificial heart valves, heart murmurs, or rheumatic heart disease**…….**Yes No**
2. **Cardiovascular heart disease (high blood pressure, heart attack, stroke, angina, coronary insufficiency, coronary occlusion, arteriosclerosis)**……... **Yes No**
   Do you have chest pain upon exertion?……... **Yes No**
   Are you ever short of breath after mild exercise or when lying down?…….…….. **Yes No**
   Do your ankles swell?……... **Yes No**
   Do you have inborn defects?…….……... **Yes No**
   Do you have a cardiac pacemaker?……**Yes No**
3. **Do you have any type of prosthesis (i.e., hip, knee, etc.)?**…… **Yes No**
   If yes, what type do you have?_____
4. **Allergies (i.e., mold, dust, smoke, etc.)**…….…….. **Yes No**
5. **Sinus Trouble**…… **Yes No**
6. **Asthma or hay fever**…… **Yes No**
7. **Fainting spells or seizures**…… **Yes No**
8. **Persistent diarrhea or recent weight loss**……... **Yes No**
9. **Diabetes**…….. **Yes No**

10. Hepatitis, jaundice, or liver disease……Yes No
11. AIDS or HIV infection……Yes No
12. Thyroid problems……Yes No
13. Respiratory problems, emphysema, bronchitis, etc……Yes No
14. Arthritis or painful swelling joints……Yes No
15. Stomach ulcer or hyperacidity…… Yes No
16. Kidney trouble…… Yes No
17. Tuberculosis…… Yes No
18. Persistent cough or cough that produces blood…… Yes No
19. Persistent swollen glands in the neck…… Yes No
20. Low blood pressure…… Yes No
21. Sexually transmitted disease…… Yes No
22. Epilepsy or other neurological disease…… Yes No
23. Problems with mental health…… Yes No
24. Cancer…… Yes No
25. Problems with the immune system…… Yes No
26. Abnormal bleeding……Yes No
27. Have you ever required a blood transfusion?…… Yes No
28. Do you have any blood disorder such as anemia?…… Yes No
29. Have you ever had any treatment for a tumor or growth?……Yes No

Are you allergic or have you had a reaction to:

Local anesthetics…… Yes No
Penicillin……Yes No
Other antibiotics, if yes please list…… Yes No
Sulfa Drugs…… Yes No
Barbiturates, sedatives, or sleeping pills……Yes No
Aspirin……Yes No
Iodine……Yes No
Codeine……Yes No
Latex……Yes No
Other_____Yes No

30. Have you had any serious trouble associated with previous dental treatment?…… Yes No
If so, please explain_____
31. Do you have any disease or condition not listed above that I should be aware of?…… Yes No
If yes, please explain_____
32. Are you wearing contact lenses?…… Yes No
33. Are you wearing removable dental appliances?…… Yes No
34. Do you have any dental implants?.....Yes No
35. Do you smoke and/or use tobacco products?…… Yes No
Packs per day?_____
36. Did you ever smoke and/or use tobacco products?……Yes No
If yes, when did you stop?_____

<u>Women Only</u>
37. Are you pregnant?…… Yes No
38. Do you have any trouble associated with your menstrual cycle?…… Yes No
39. Are you nursing?…… Yes No
40. Are you taking birth control pills?…… Yes No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I am aware that I am responsible for my account, regardless of insurance coverage. I am also aware that I am responsible for any reasonable collection costs and/or attorney fee should my account become delinquent.

X_____
Signature of patient (parent, if minor)