MISSION DENTAL ARTS

Medical History

Name_____ Height ____' ____" Weight _____lbs. Date_____
Last First Middle

1. Are you in good health? ..... Yes No
2. 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 yes, for what? _____
5. The name and address of my physician(s) is_____
   _____
   Office Address Telephone
6. Have you ever been hospitalized in the past 5 years? ..... Yes No
   If yes, please explain _____
7. Are you ALLERGIC or have you ever experienced a reaction to any of the following?
   - Local Anesthetic ..... Yes No
   - Penicillin or Other Antibiotics ..... Yes No
   - Sulfa Drugs ..... Yes No
   - Barbiturates, Sedatives, Narcotics ..... Yes No
   - Aspirin ..... Yes No
   - Iodine ..... Yes No
   - Codeine ..... Yes No
   - Other ..... Yes No

8. Have YOU EVER or are you CURRENTLY taking any of the following?
   - Blood Thinners/Aspirin ..... Yes No
   - Blood Pressure Medications ..... Yes No
   - Insulin / Diabetes Medications ..... Yes No
   - Steroids/Cortisone ..... Yes No
   - Thyroid Medication ..... Yes No
   - Heart Medications ..... Yes No
   - Nitroglycerin ..... Yes No
   - Fenfluramine (Pondimin) ..... Yes No
   - Dexfenfluramine (Redux) ..... Yes No
   - Phentermine ..... Yes No
   - Fen / Phen ..... Yes No
   - Bisphosphonates (Zometa, Actonel, Fosamax) ..... Yes No
9. Please list all medications and dosages below
   _____
   _____
10. Do you smoke? If yes how much? ..... Yes No
11. Do you drink alcohol? If yes how much? ..... Yes No
12. Do you use any illicit drugs or medications? ..... Yes No

13. Do you HAVE or have you EVER had any of the following?

GENERAL	YES	NO
Tire Easily, Weakness	☐	☐
Marked Weight Change	☐	☐
Night Sweats	☐	☐
Persistent Fever	☐	☐
Eruptions/Rash/Hives	☐	☐
Change In Skin Color	☐	☐
Visual Change	☐	☐
Glaucoma	☐	☐
Loss Of Hearing	☐	☐
Ringing In Ears	☐	☐
Frequent Nosebleeds	☐	☐
Sinus Problems	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Convulsions/Epilepsy/Seizures	☐	☐
Headaches	☐	☐
Numbness/Tingling	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Psychiatric Treatment	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family History Of Diabetes	☐	☐
Thyroid Condition/Goiter	☐	☐

CARDIOVASCULAR	YES	NO
Rheumatic Fever	☐	☐
Heart Murmur / Heart Defects	☐	☐
Chest Pain/Discomfort	☐	☐
Heart Attack/Heart Trouble	☐	☐
Shortness Of Breath	☐	☐
Swelling Of Ankles	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Heart Defects	☐	☐
Mitral Valve Prolapse	☐	☐
Artificial Heart Valve	☐	☐
Pacemaker	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change In Appetite	☐	☐
Bloody/Coffee Ground Vomitus	☐	☐
Black, Bloody Or Pale Stools	☐	☐
Liver Disease / Cirrhosis	☐	☐
GENITO / URINARY		
Kidney Disease	☐	☐
Frequent Urination	☐	☐
Burning On Urination	☐	☐
Urethral Discharge	☐	☐
Bloody Urine	☐	☐
Sexually Transmitted Disease	☐	☐

RESPIRATORY	YES	NO
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/Hay Fever	☐	☐
Persistent Cough	☐	☐
Sputum Production/Phlegm	☐	☐
Cough Up Bloody Sputum	☐	☐
Difficulty Breathing	☐	☐
BLOOD		
Abnormal Bleeding	☐	☐
Bruise Easily	☐	☐
Anemia	☐	☐
Blood Transfusions	☐	☐
Aids/Arc/Hiv	☐	☐
NEOPLASMS		
Cancer	☐	☐
Tumors Or Growths	☐	☐
Chemotherapy/Radiation Therapy	☐	☐
BONE/MUSCLES		
Arthritis/Rheumatism	☐	☐
Artificial Joints	☐	☐
WOMEN		
Are you Pregnant?	☐	☐
Are you Nursing?	☐	☐
Are You Taking Birth Control Pills?	☐	☐

I certify that I have read and understand the two page Medical / Dental History Forms 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 Doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of these forms.

X_____ _____

Signature of Patient, Parent, or Guardian Date

Medical History Updates:

Date	Please Note Any Changes in Your Medical History Since You Last Filled out These Forms	Patient Signature	Doctor Review

For Completion by the Doctor

Patient management considerations and comments if any:

_____

_____

_____

_____

_____ _____

Doctor Signature Date