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
   - Latex ..... 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
   - 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	CARDIOVASCULAR	YES	NO	RESPIRATORY	YES	NO
Tire Easily, Weakness	☐	☐	Rheumatic Fever	☐	☐	Tuberculosis	☐	☐
Marked Weight Change	☐	☐	Heart Murmur / Heart Defects	☐	☐	Emphysema	☐	☐
Night Sweats	☐	☐	Chest Pain/Discomfort	☐	☐	Asthma/Hay Fever	☐	☐
Persistent Fever	☐	☐	Heart Attack/Heart Trouble	☐	☐	Persistent Cough	☐	☐
Eruptions/Rash/Hives	☐	☐	Shortness Of Breath	☐	☐	Sputum Production/Phlegm	☐	☐
Change In Skin Color	☐	☐	Swelling Of Ankles	☐	☐	Cough Up Bloody Sputum	☐	☐
Visual Change	☐	☐	High Blood Pressure	☐	☐	Difficulty Breathing	☐	☐
Glaucoma	☐	☐	Low Blood Pressure	☐	☐			
Loss Of Hearing	☐	☐	Heart Defects	☐	☐	**BLOOD**		
Ringing In Ears	☐	☐	Mitral Valve Prolapse	☐	☐	Abnormal Bleeding	☐	☐
Frequent Nosebleeds	☐	☐	Artificial Heart Valve	☐	☐	Bruise Easily	☐	☐
Sinus Problems	☐	☐	Pacemaker	☐	☐	Anemia	☐	☐
						Blood Transfusions	☐	☐
NERVOUS SYSTEM			**DIGESTIVE SYSTEM**			Aids/Arc/Hiv	☐	☐
Stroke	☐	☐	Hepatitis	☐	☐			
Convulsions/Epilepsy/Seizures	☐	☐	Jaundice	☐	☐	**NEOPLASMS**		
Headaches	☐	☐	Ulcers	☐	☐	Cancer	☐	☐
Numbness/Tingling	☐	☐	Change In Appetite	☐	☐	Tumors Or Growths	☐	☐
Dizziness	☐	☐	Bloody/Coffee Ground Vomitus	☐	☐	Chemotherapy/Radiation Therapy	☐	☐
Fainting	☐	☐	Black, Bloody Or Pale Stools	☐	☐			
Psychiatric Treatment	☐	☐	Liver Disease / Cirrhosis	☐	☐	**BONE/MUSCLES**		
						Arthritis/Rheumatism	☐	☐
ENDOCRINE			**GENITO / URINARY**			Artificial Joints	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐			
Family History Of Diabetes	☐	☐	Frequent Urination	☐	☐	**WOMEN**		
Thyroid Condition/Goiter	☐	☐	Burning On Urination	☐	☐	Are you Pregnant?	☐	☐
			Urethral Discharge	☐	☐	Are you Nursing?	☐	☐
			Bloody Urine	☐	☐	Are You Taking Birth Control Pills?	☐	☐
			Sexually Transmitted Disease	☐	☐			

I certify that i have read and understand the two page Medical/Dental history forms above. I acknowledge that my questions, if any, about me 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