Paulette R. Sanford, D.D.S.

Medical History Form

Date_____

Name_____Home Phone_____

Address_____Business Phone_____

City_____State_____Zip_____Cell Phone or Pager_____

Occupation_____Social Security Number_____

Date of Birth____/____/____Sex M F Name of Spouse or closest relative_____Phone_____

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

WHAT IS THE PURPOSE OF YOUR VISIT TODAY?

Please answer yes or no to all of the following questions, whichever applies. Your answers are for our records and will be considered confidential. During your initial visit, you may be asked questions regarding your responses.

Please Circle

Yes No Are you in good health?

Yes No Has there been any changes in your general health within the past year?

Date of your last physical exam?_____

Physician name_____

_____

Yes No Have you had any serious illness, operation, or been hospitalized in the last five years?

Yes No Are you presently taking any medication(s)? If so, what medication(s) are you taking?

_____

_____

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

Yes No Damaged heart valves or artificial heart valves heart murmur or rheumatic heart disease

Cardiovascular disease (heart trouble, heart attack, angina, coronary arteriosclerosis, stroke)

Yes No Do you have chest pain upon excertion?

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 heart defects?

Yes No Do you have a pacemaker?

Yes No Do you have thyroid problems?

Yes No Do you have arthritis or painful joints?

Yes No Do you have kidney problems?

Yes No Do you have sexually transmitted disease? _____

Yes No Do you have or have you had Cancer?

Yes No Have you ever taken Phen Fen?

Yes No Are you allergic or have you had a reaction to:

a. Local anesthetics
b. Antibiotics: Penicillin or others
c. Sulfa drugs
d. Barbiturates, sedatives or others
e. Aspirin or Ibuprofen
f. Codeine or other narcotics
g. Latex

Other_____

Yes No Do you have eye disorders?

Yes No Do you have emotional problems or are you under psychiatric care?

Yes No Do you have sinus trouble?

Yes No Do you have asthma or hay fever?

Yes No Ever heve fainting spells or seizures?

Yes No Do you have Diabetes? Type II or I?

Yes No Hepatitis, jaundice or liver disease?

Yes No Respiratory problem, emphysema, bronchitis, etc.?

Yes No Stomach or hyperacidity?

Yes No Do you have or have you had tuberculosis?

Yes No Epilepsy or other neurological disease?

Yes No Problems of the immune system?

Yes No Do you wear contact lenses?

Yes No Women: a. Are you pregnant?

Yes No b. Are you nursing?

Yes No c. Are you taking birth control pills?

Yes No Do you have any disease, condition or problem not listed you think the Doctor should know about?_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient