Medical History Form Date: _____

Name_____ Sex M F
Last First Middle Preferred

Date of Birth ____/____/____ Home Phone _____ Work Phone _____
Cell Phone _____ Name of Spouse/Closest Relative _____ __ Phone _____
If you are completing this form for another person, what is your relationship to that person? _____
Email Address_____ This may be used for confirming appointments

For the following questions, please *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 may be asked some health 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. My last physical exam was on _____
3. Has there been any change in your general health within the past year? YES NO
4. Are you now under the care of a physician? YES NO If so, what condition is being treated? _____
_____
5. The name and address of my physician is : _____
_____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? YES NO
7. Are you taking any medicine(s) including non-prescription? YES NO If so, what medicine(s) are you taking? _____
_____
8. Do you have or have you had any of the following diseases or problems?

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

c. Allergy	YES NO	m. Kidney trouble	YES NO
d. Sinus trouble	YES NO	n. Tuberculosis	YES NO
e. Asthma	YES NO	o. Persistent cough or cough that produces blood	YES NO
f. Seizures	YES NO	p. Persistent swollen glands in neck	YES NO
g. Diabetes	YES NO	q. Low Blood Pressure	YES NO
h. Hepatitis, jaundice, liver disease	YES NO	r. Sexually transmitted diseases	YES NO
i. AIDS or HIV infection	YES NO	s. Epilepsy or other neurological disease	YES NO
j. Thyroid problems	YES NO	t. Problems with mental health	YES NO
k. Respiratory problems, emphysema,		u. Cancer	YES NO
bronchitis, etc.,	YES NO	v. Problems with immune system	YES NO
l. Arthritis or painful swollen joints	YES NO	w. Stomach ulcer or hyperactivity	YES NO
9. Have you had abnormal bleeding?	YES NO	Have you ever required a blood transfusion?	YES NO

10. Do you have any blood disorder such as anemia? YES NO
11. Have you ever had any treatment for a growth or tumor? YES NO
12. Are you allergic or have you had a reaction to:

a. Local anesthetics	YES NO	f. Iodine	YES NO
b. Penicillin or other antibiotics	YES NO	g. Codeine or other narcotics	YES NO
c. Sulfa Drugs	YES NO	h. Latex	YES NO
d. Barbiturates, sedatives or sleeping pills	YES NO	i. Other _____	
e. Aspirin	YES NO	_____	

Medical History Form Page 2 **Date** _____

Name _____ Date of Birth _____/_____/_____

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 taking birth control pills? YES NO

19. Are you taking birth control pills? YES NO

20. Do you have any problems associated with your menstrual period? YES NO

Chief Dental Complaint _____

_____

For confidential purposes, upon confirming appointments may we leave a message at home? YES NO

At work? YES NO On your cell phone? YES NO

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

_____

_____

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	**Comment**	**Signature**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____