Medical History Form

Name (Last)__________________________(MI)_____(First)___________________(Prefered)___________________

Date of Birth___/____/____ Sex: (Male) (Female) Today's Date____________________

For the following questions, circle Yes or No. Your answers are for our records only, answers 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 your general health in the past year? Yes No
3. My last physical examination was on?___________________________
4. Are you under the care of a physician now? Yes No
   If so, what is the condition you are being treated for?_____________________________________
5. The name and address of my physician(s) is____
   ____
   ____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
   If so, what was the illness or problem?____
7. Are you taking any medicine(s) including non-prescription medicine? Yes No
   If so what medicine(s) are you taking?____
8. Have you ever been treated for alcohol or chemical dependency? Yes No
9. Do you currently smoke or use smokeless tobacco products? Yes No
   If yes, how many packs/times per day? _________ For how many years?_________
   If former smoker, when did you quit?___________
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves or artificial 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
       1. Do you have inborn heart defect? Yes No
       2. Do you have a cardiac pacemaker? Yes No
       3. Have you ever taken Redux or Phen Phen? Yes No
    c. Allergies Yes No
    d. Sinus trouble Yes No
    e. Asthma Yes No
    f. Seizures Yes No
    g. Diabetes Yes No
    h. Hepatitis, jaundice or liver disease Yes No
    i. AIDS or HIV infection Yes No
    j. Thyroid problems Yes No
    k. Respiratory problems, emphysema, Bronchitis, etc. Yes No
    l. Arthritis or painful swollen joints Yes No
    m. Stomach ulcer or hypersacidity Yes No
    n. Kidney trouble Yes No
    o. Tuberculosis Yes No
    p. Persistent cough or cough that produces blood Yes No
    q. Persistent swollen glands in neck Yes No
    r. Low blood pressure Yes No
    s. Sexually transmitted diseases Yes No
    t. Epilepsy or other neurological disease Yes No
    u. Problems with mental health Yes No
    v. Cancer Yes No
    w. Problems of the immune system Yes No
    x. Had any lesions or growths in mouth Yes No
11. Have you had abnormal bleeding? Yes No
    a. Have you ever required a blood transfusion? Yes No
12. Do you have any blood disorders such as anemia? Yes No
13. Have you ever had any treatment for a tumor or growth? Yes No

14. 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			

15. Have you had any serious trouble associated with any previous dental treatment? Yes No
    If yes, explain____

16. Do you have any disease, condition, or problem not listed above that you think I should know about?
    ____
    ____

17. Are you wearing contact lenses? Yes No
18. Are you wearing removable dental appliances (such as a flipper, partial, denture etc.?) Yes No
19. Do you snore? Yes No
20. Do you wake up tired? Yes No
    If you answered yes to #19 and #20: These are the two most common symptoms of sleep apnea. Untreated sleep apnea raises your risk of serious health issues which can include: High blood pressure, stroke, heart disease, diabetes, chronic acid reflux, and erectile dysfunction. Ask us how a dental appliance may help.

Women

21. Are you pregnant? Yes No
    If yes, how far along? ________________
22. Do you have any problems associated with your menstrual period? Yes No
23. Are you nursing? Yes No
24. Are you taking birth control (pills, shot, patch etc.?) Yes No

Notice to all patients: Per a new standard of care for our office, each patient will receive the VELscope screening once a year. Per office policy there is a $36 per hour scheduled for missed appointments.

Chief Dental Complaint ____

For confidential purposes, upon confirming appointments may we leave a message at home? Yes No (circle one) at work? Yes No (circle one)

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth 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. **Patient Signature**______________________________ **Date**________

OFFICE USE ONLY:

Dentist Signature____ Date ______________