MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health?..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician?..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years?..... Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8 Have you ever been told that you need to pre-medicate with antibiotics before any dental treatment due to heart issues such as a heart murmur or due to artificial joint replacement? ..... Yes No
9. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa) ? ..... Yes No
10. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies?..... Yes No
    If so, please list:
    _____
    _____
    _____
    _____
    _____
11. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
    b. Rheumatic Heart Disease ..... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
        1. Chest pain upon exertion?..... Yes No
        2. Shortness of breath after mild exercise? ..... Yes No
        3. Do your ankles swell?..... Yes No
    d. Allergies ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma or hay fever..... Yes No
    g. Fainting spells or seizures..... Yes No
    h. Diabetes..... Yes No
    i. Hepatitis, jaundice or liver disease..... Yes No
    j. Frequent or recurring mouth sores..... Yes No
    k. Thyroid problems ..... Yes No
    l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ)..... Yes No
    n. Osteoporosis ..... Yes No
    o. Stomach ulcer or hyperacidity..... Yes No

p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough that produces blood ..... Yes No
s. Persistent swollen neck glands ..... Yes No
t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer ..... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

12. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
13. Do you have any blood disorder such as anemia? ..... Yes No
14. Have you ever had treatment for a tumor or growth? ..... Yes No
15. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
16. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other ..... Yes No
17. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
    _____
18. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
19. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____
20. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
21. Are you wearing contact lenses? ..... Yes No
22. Are you wearing removable dental appliances? ..... Yes No
23. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

24. Are you pregnant or trying to become pregnant ..... Yes No
25. Do you have problems associated with your menstrual period? ..... Yes No
26. Are you nursing? ..... Yes No
27. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint: _____

Date of last visit to a dentist _____
Reason for your last visit? _____
Date you last had dental x-rays? _____
Have you ever fainted during a dental visit? ..... Yes No
    If yes, explain: _____
Have you experienced an unusual reaction to dental medication or anesthetic? ..... Yes No
    If yes, explain: _____
Have you experienced prolonged bleeding following dental treatment? ..... Yes No
    If yes, explain: _____

Have you had any other complications following dental treatment? …… Yes No
If yes, explain: _____
Have you had any injury to your teeth, jaws or face? ……Yes No
If yes, explain: _____
Are you happy with the appearance of your teeth? …… Yes No
Do your gums bleed when you brush your teeth or when you eat? ……Yes No
Does food or dental floss catch between your teeth? ……..Yes No
Are some of your teeth becoming loose? ……Yes No
Are there spaces between your teeth now where there were none before? …… Yes No
Are any of your teeth sensitive to hot, cold or pressure? …… Yes No
Do any of your teeth ache? ..... Yes No
Do you experience pain or clicking in your jaw joints? …… Yes No
Do you clench your teeth…… Yes No
Do you get cold sores?..... Yes No
Are there any sores or growths in your mouth? ……Yes No
Have you ever been told that you snore?..... Yes No
Are you worried about receiving dental treatment? ……. Yes No
Do you have any other dental concerns or complaints? ……Yes No
If yes, explain:_____
_____

SIGNATURE OF PATIENT: *I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best treatment possible.*

PERSON COMPLETING THIS FORM:
Signature _____ Date _____
If other than patient, indicate relationship: _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____
_____
_____
_____

Significant findings from questionnaire or oral interview: _____
_____
_____
_____

Dental management considerations: _____
_____
_____
_____

Date:_____ Doctor's Signature:_____