

MEDICAL HISTORY FORM

Patient's Name (Please Print) _____

Date _____

Height _____ Weight _____

For the following questions, circle yes or no, whichever apply. Your answers are for our records only and 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.

- | | | |
|-----|----|---|
| Yes | No | Are you in good health? |
| Yes | No | Has there been any change in your general health within the past year? |
| | | Your last physical examination was on: _____ |
| Yes | No | Are you now under the care of a physician? |
| | | If so, what condition is being treated? Name and address of physician(s): _____ |
| Yes | No | Have you had any serious illness, operation or been hospitalized in the past five years? _____ |
| Yes | No | Are you or have you ever taken a biophosphonate medication (eg. Fosamax, Actonel, Boniva, Zometa, etc.) |
| Yes | No | Have you ever been instructed to take an antibiotic prior to dental treatment? |

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

- | | | |
|-----|----|--|
| Yes | No | Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis or stroke)? |
| Yes | No | Tetralogy of fallot |
| Yes | No | Coronary palliative shunt or conduit repairs |
| Yes | No | Transposition of the Great Arteries |
| Yes | No | Single heart ventricle |
| Yes | No | Inborn heart defects |
| Yes | No | Cardiac pacemaker |
| Yes | No | Chest pain upon exertion |
| Yes | No | Low blood pressure (hypotension) |
| Yes | No | High blood pressure (hypertension) |
| Yes | No | Shortness of breath |
| Yes | No | Swelling in ankles |
| Yes | No | Emphysema, bronchitis, etc. |
| Yes | No | Asthma or hay fever |
| Yes | No | Cough that produces blood |
| Yes | No | Persistent cough |
| Yes | No | Sinus trouble |
| Yes | No | Tuberculosis |
| Yes | No | Allergy to local anesthetics |
| Yes | No | Penicillin or other antibiotic allergy |
| Yes | No | Sulfa drug allergy |
| Yes | No | Barbiturates or sedatives allergy |
| Yes | No | Aspirin sensitivity |
| Yes | No | Iodine allergy |
| Yes | No | Codeine or other narcotic allergy |
| Yes | No | Latex Allergy |
| Yes | No | Other allergies: _____ |
| Yes | No | Immune system problems |
| Yes | No | Do you have any disease, condition or problem not listed above that you think we should know about? |

- | | | |
|-----|----|---|
| Yes | No | Hepatitis, jaundice or liver disease |
| Yes | No | AIDS or HIV infection |
| Yes | No | Sexually transmitted disease |
| Yes | No | Persistent diarrhea or recent weight loss |
| Yes | No | Stomach ulcer or hyper acidity |
| Yes | No | Epilepsy or other neurological disease |
| Yes | No | Fainting spells or seizures |
| Yes | No | Blood disorder or anemia |
| Yes | No | Abnormal bleeding |
| Yes | No | Growth or tumor: _____ |
| Yes | No | Cancer: _____ |
| Yes | No | Diabetes |
| Yes | No | Thyroid problems |
| Yes | No | Kidney trouble |
| Yes | No | Artificial joint: _____ |
| Yes | No | Arthritis or painful swollen joints |
| Yes | No | Contact lenses |

- Women:**
- | | | |
|-----|----|---------------------|
| Yes | No | Pregnant |
| Yes | No | Birth Control Pills |
| Yes | No | Nursing |

Yes No Are you taking any medications including non-prescription medication?
If so, what medication(s) are you taking? (Please use the bottom of this page if you need more space)

Medication:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I certify that I have read and understand the information on the reverse side. 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 staff responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature (Guardian for Minors) _____
Date

Additional signatures for future appointments:

Patient's Signature (Guardian for Minors) _____
Date

Patient's Signature (Guardian for Minors) _____
Date

Patient's Signature (Guardian for Minors) _____
Date

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Date

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