MEDICAL HISTORY FORM

Name:__________________________________ Sex: M / F Date:__________________________________

Date of Birth: ______________________________ Age: _____ Height:___________Weight: ______________

General Dentist: ____________________ Referral Source (if different from dentist): _______________________

Occupation: ____

Reason for today's visit / chief dental complaint: ____

____

____

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

1. My last physical exam was on ___________/_____/______
2. Are you now under the care of a physician?.. Yes No
   If so, for what condition? ____
3. The name of my physician is:____
4. Have you had any serious illness, operation or hospitalization within the past 5 years? ...... Yes No
   If so, please explain: ____
5. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? .... Yes No
6. Do you have a serious congenital heart condition .... Yes No
7. Do you have a history of infective endocarditis .... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia or Zometa)? .... Yes No
9. 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. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, cholesterol problems or any other heart condition (please circle all that apply)………………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
   c. Asthma or hay fever .... Yes No
   d. Respiratory problems, emphysema, bronchitis, tuberculosis, etc.................................. Yes No
   e. Persistent cough or cough that produces blood .... Yes No
   f. Sleep apnea .... Yes No
   g. Persistent swollen neck glands .... Yes No
   h. Fainting spells or seizures.. Yes No
   i. Epilepsy or neurological disorder .... Yes No
   j. Diabetes .... Yes No
   k. Hepatitis, jaundice or liver disease... Yes No
   l. Thyroid problems.. 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. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
10. Have you had abnormal bleeding? .... Yes No
    a. Have you ever required a blood transfusion?.. Yes No
11. Do you have any blood disorder such as anemia (including sickle cell anemia)?................ Yes No
12. Have you ever had treatment for a tumor or growth (i.e. cancer)? .... Yes No

13. Have you had radiation therapy to the head, neck or jaws? .... Yes No

14. Are you *taking* any of the following medications:
   a. Antibiotic or sulfa drug .... Yes No
   b. Anticoagulants (blood thinners) .... Yes No
   c. Medication for high blood pressure .... Yes No
   d. Corisone (steroids – including prednisone) .... Yes No
   e. Tranquilizers .... Yes No
   f. Aspirin, ibuprofen (Advil, Motrin), acetaminophen (Tylenol) .... Yes No
   g. Insulin .... Yes No
   h. Digitalis (drugs for heart trouble) .... Yes No
   i. Nitroglycerin .... Yes No
   j. Antihistamine .... Yes No
   k. Other (including diet pills, herbal supplements, homeopathic or natural remedies) .... Yes No
   If yes, please specify: ____

15. 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
   d. Barbiturates or sleeping pills .... 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

16. Have you had any serious trouble associated with previous dental treatment? .... Yes No
   If so, explain: ____
   ____

17. Do you have any other condition or disease you think the doctor should know about? .... Yes No
   If so, explain: ____

18. Do you have a nervous / psychiatric condition (including depression / anxiety) .... Yes No
   If yes, please explain: ____

19. Do you smoke or chew tobacco? .... Yes No
   If yes, how much daily? ____

20. Do you drink alcoholic beverages? .... Yes No
   If yes, how much daily? ____

21. Do you have a sexually transmitted disease (gonorrhea, syphilis, genital warts, HIV, AIDS) .... 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

25. Are you pregnant or trying to become pregnant .... Yes No
26. Do you have problems associated with your menstrual period? .... Yes No
27. Are you nursing? .... Yes No
28. Are you taking oral contraceptive / hormonal therapy? .... Yes No

---

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient's Signature: ____________________ **Physician's Signature:** ________________________