Medical History Form

Date _____

(Circle One) Mr. Mrs. Ms Miss Dr. Name _____ (Last) (First) (Middle)

Home Phone: ( ) _____ Business Phone: ( ) _____ Cell Phone: ( ) _____

Address _____ (Number, Street) E-mail: _____

City _____ State _____ Zip Code _____

Occupation: _____ Social Security No. _____

Date of Birth ___/___/___ (mo. day year) Sex M F Height _____ Weight _____ Name of Spouse _____

Contact person in case of emergency _____ Phone: ( ) _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by _____ Name of Dental Insurance _____

For the following questions, *check the box 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 will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

	Yes	No
1. Are you in good health?	☐	☐
2. Has there been any change in your general health within the last year?	☐	☐
3. My last physical examination was on _____		
4. Are you now under the care of a physician? If so, what is the condition being treated? _____	☐	☐
5. The name and address of my physician(s) is: _____ _____ _____		
6. Have you had any serious illness, operations, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____	☐	☐
7. Are you taking any medicine(s) including non-prescription medicine?	☐	☐
a. Do you take Aspirin on a regular basis?	☐	☐
b. Are you taking blood thinners? _____	☐	☐
Please list any other medicine(s) _____ _____ _____ _____		
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?	☐	☐
b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?	☐	☐
1. Do you have chest pain upon exertion?	☐	☐
2. Are you ever short of breath after mild exercise or when lying down?	☐	☐
3. Do your ankles swell?	☐	☐
4. Do you have inborn heart defects?	☐	☐
5. Do you have a cardiac pacemaker?	☐	☐
c. Allergy	☐	☐
d. Sinus trouble	☐	☐
e. Asthma	☐	☐
f. Hay fever	☐	☐
g. Fainting spells or seizures	☐	☐
h. Persistent diarrhea or recent weight loss	☐	☐
i. Diabetes	☐	☐
j. Hepatitis, jaundice or liver disease	☐	☐
k. AIDS or HIV infection	☐	☐
l. Thyroid problems	☐	☐
m. Respiratory problems, emphysema, bronchitis, etc.	☐	☐
n. Arthritis or painful swollen joints	☐	☐
o. Stomach ulcer or hyperacidity	☐	☐
p. Kidney trouble	☐	☐
q. Tuberculosis	☐	☐
r. Persistent cough or cough that produces blood	☐	☐
s. Persistent swollen glands in neck	☐	☐
t. Low blood pressure	☐	☐
u. Sexually transmitted disease	☐	☐
v. Epilepsy or other neurological disease	☐	☐
w. Problems with mental health	☐	☐
x. Cancer	☐	☐
y. Problems of the immune system	☐	☐
z. History of alcohol or drug abuse	☐	☐
9. Have you had abnormal bleeding?	☐	☐
a. Have you ever required a blood transfusion?	☐	☐
10. Do you have any blood disorder such as anemia?	☐	☐
11. Have you been treated for a tumor or growth?	☐	☐
12. Are you allergic or have you had a reaction to:	☐	☐
a. Local anesthetics	☐	☐
b. Penicillin	☐	☐
c. Sulfa drugs	☐	☐
d. Antibiotics	☐	☐
e. Barbiturates, sedatives, or sleeping pills	☐	☐
f. Aspirin	☐	☐
g. Iodine	☐	☐
h. Codeine or other narcotics	☐	☐
i. Latex	☐	☐
Other _____ _____		

	Yes	No
13. Do you smoke?	☐	☐
a. How much per week? _____		
14. Do you use recreational drugs?	☐	☐
15. How much alcohol do you consume in a week? _____		
16. Are you wearing contact lenses?	☐	☐
17. Are you wearing removable dental appliances?	☐	☐
18. Do you have an artificial hip or other joint replacement?	☐	☐
If yes, date of placement _____		
19. Have you had any serious trouble associated with any previous dental treatment?	☐	☐
If so, explain _____		

Women	Yes	No
21. Are you pregnant?	☐	☐
22. Are you nursing?	☐	☐
23. Are you taking birth control pills?	☐	☐

20. Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐
If so, explain _____

Chief Dental Complaint _____

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 (Parent if under 18 years of age)

For completion by the dentist.
Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

_____ _____
(Date) Signature of Dentist

Medical history update:

Date	Comments:	Signature