



MEDICAL HISTORY FORM

Name: _____

Date: _____

Date of Birth: _____

Sex: M / F

Height: _____ Weight: _____

Please circle "YES" or "NO" for the follow questions. 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
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. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)? Yes No
9. Are you taking ANY medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? Yes No
10. 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
c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition
1. Chest pain upon exertion?
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 |
| 11. Have you had abnormal bleeding?..... | Yes | No |
| a. Have you ever required a blood transfusion? | Yes | No |
| 12. Do you have any blood disorder such as anemia? | Yes | No |
| 13. Have you ever had treatment for a tumor or growth? | Yes | No |
| 14. Have you had radiation therapy to the head, neck or jaws?..... | Yes | No |
| 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 smoke or chew Tobacco? | Yes | No |
| If yes, how much? _____ | | |
| 19. Is there any past history of alcohol or chemical dependency or emotional disorder
that may affect the care we provide you? | Yes | No |
| 20. Are you wearing contact lenses? | Yes | No |
| 21. Are you wearing removable dental appliances? | Yes | No |
| 22. Do you wish to talk with the doctor privately about anything? | Yes | No |

Women:

- | | | |
|---|-----|----|
| 20. Are you pregnant or trying to become pregnant? | Yes | No |
| 21. Do you have problems associated with your menstrual period? | Yes | No |
| 22. Are you nursing? | Yes | No |
| 23. Are you taking birth control pills?..... | Yes | No |

Main Dental Concern: _____

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: _____ Date: _____

Doctor's Signature: _____ Date: _____