Medical History Form

Name ______________________________ Home Phone (______) __________________

Address ______________________________ Business Phone (______) __________________

City ____________________ State ________ Zip Code ____________ Cell Phone (______) __________________

Email Address ______________________________

Occupation ________________ Employer ________________ Social Security No. ________________

Date of Birth ___/___/___ Sex M F Height ________ Weight ________ Single ________ Married ________________

Spouse / Partner / Parent ________________ Closest Relative ________________ Phone (______) ________________

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

Referred by ______________________________

For the following questions, circle yes or no, whichever applies. Your answers are for your 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.

1. Are you in good health? .... Yes No
2. Has there been any change in your general health within the past year? .... Yes No
3. My last physical examination was on ______________________________
4. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ______________________________
5. The name and address of my physician(s) ______________________________

   ____
6. Have you had any serious illness, operation, eye surgery or been hospitalized in the past 5 years? .... Yes No
   If so, what was the illness or problem? ______________________________
7. Are you taking any medication(s) including non-prescription medication? .... Yes No
   If so, what medicine(s) are you taking? ______________________________
   Are you taking any herbal remedies? Kava Kava? St. John's Wort? Valerian Root? .... Yes No
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 .... Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .... Yes No
      1. Do you have chest pain upon exertion? .... Yes No
      2. Are you ever short of breath after mild exercise or when lying down? .... Yes No
      3. Do your ankles swell? .... Yes No
      4. Do you have any prosthetic joints or pins in your body? .... Yes No
      5. Do you have a cardiac pacemaker? .... Yes No
      6. Do you have mitral valve prolapse or inborn heart defects? .... Yes No
      7. Do you take blood thinners (i.e. Coumadin)? .... Yes No
   c. Allergy .... Yes No
   d. Sinus trouble .... Yes No
   e. Asthma or hay fever .... Yes No
   f. Fainting spells or seizures .... Yes No
   g. Persistent diarrhea or recent weight loss .... Yes No
   h. Diabetes .... Yes No
   I. Hepatitis, jaundice or liver disease .... Yes No
   j. AIDS or HIV infection .... Yes No
   k. Thyroid problems .... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
   m. Arthritis or painful swollen joints .... Yes No
   n. Stomach ulcer or hyperacidity .... Yes No
   o. Kidney trouble .... Yes No
   p. Tuberculosis .... Yes No
   q. Persistent cough or cough that produces blood .... Yes No
   r. Persistent swollen glands in neck .... Yes No
   s. Low blood pressure .... Yes No
   t. Sexually transmitted disease .... Yes No
   u. Epilepsy or other neurological disease .... Yes No
   v. Problems with mental health .... Yes No
   w. Cancer .... Yes No
   x. Problems of the immune system .... Yes No
9. Have you had abnormal bleeding? .... Yes No
10. Do you have any blood disorder such as anemia? .... Yes No
11. Have you ever had any treatment for a tumor or growth? .... Yes No
12. Do you use cocaine or recreational drugs that may interact with dental local anesthetics? .... Yes No
13. Are you allergic or have you had a reaction to:
    a. Local anesthetics .... Yes No
    b. Penicillin or other antibiotics .... Yes No
    c. Sulfa drugs .... Yes No
    d. Barbiturates, sedatives, or sleeping pills .... Yes No

e. Aspirin .... Yes No
f. Iodine .... Yes No
g. Codeine or other narcotics .... Yes No
h. Latex or other .... Yes No

14. **Are you happy with the appearance of your smile? .... Yes No**
If not, explain____

15. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
If so, explain____
16. Are you wearing contact lenses? .... Yes No
17. Are you wearing removable dental appliances? .... Yes No
18. How long has it been since your last dental hygiene care appointment?________________________
19. Do you have lumps or sores in your mouth now? .... Yes No
20. Have you ever been treated for gum or periodontal disease? .... Yes No
If so, when?____
How was the infection treated?____
21. Do hot, cold, or sweet beverages cause discomfort or pain in your mouth? .... Yes No
22. Do your gums bleed? .... Yes No
If so, when?____
23. Do you clench or grind your teeth? .... Yes No
24. Do you wear a night guard or a bite plate? .... Yes No
25. Do you smoke or use any other tobacco products? .... Yes No
26. Are you nervous about dental treatment? .... Yes No
27. Have you ever had an unpleasant experience in the dental office? .... Yes No
28. What are your primary dental concerns now?____
29. **Are you interested in whitening your teeth? .... Yes No**
30. Do you wear a sports guard during participation of sporting events? .... Yes No
31. What sports do you play? ....
32. Do you use an electric toothbrush? .... Yes No
33. **Do you have chronic bad breath? .... Yes No**
34. Do you experience frequent canker sores? .... Yes No
35. Do you get fever blisters - i.e., oral herpes? .... Yes No
36. Do you take bisphosphonates to treat osteoporosis and similar diseases? .... Yes No

WOMEN

37. Are you pregnant? .... Yes No
38. Do you have any problems associated with your menstrual period? .... Yes No
39. Are you nursing? .... Yes No
40. Are you taking birth control pills? .... Yes No

Chief Dental Complaint

____
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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 staff, responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of Patient

FOR COMPLETION BY THE DENTIST

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

______________________________	______________________________
Date	**Signature of Dentist**

Medical history update:

Date:	Comments:	Signature: