Medical History Form

Date ______________________

Name ______________________ Home Phone (___)______________

Address ______________________ Business Phone (___)______________

City ______________ State ________ Zip Code ________

Occupation ______________________ Social Security No.______________

Date of Birth (month/day/year) ____/____/____ Sex M F Height _______ Weight ________

____ Single ____ Separated ____ Divorced ____ Married - Name of Spouse ______________

Name of Closest Relative Not in Household______________Phone (___) ______________

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

How did you hear about our office?______________________

The name and address of my physician(s) is ______________________

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For the following questions, circle *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.

1.	Yes	No	Are you in good health?
2.			My last physical examination was on ______________________
3.	Yes	No	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what for? ______________________
4.	Yes	No	Have you ever required a blood transfusion?
5.	Yes	No	Are you now under the care of a physician? ______________________
6.	Yes	No	Are you taking any medicine(s) including non-prescription medicine? If so, what medicine are you taking? ______________________
7..	Yes	No	Has there been any change in your general health within the past year? If so, what is the condition being treated? ______________________

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

8.			Are you allergic or have you had a reaction to:
	Yes	No	..... Local anesthetics?
	Yes	No	..... Latex ?
	Yes	No	..... Penicillin or other antibiotics? Please list those you are allergic to ______________
	Yes	No	..... Sulfa drugs?
	Yes	No	..... Barbiturates, sedatives, or sleeping pills?
	Yes	No	..... Aspirin?
	Yes	No	..... Iodine?
	Yes	No	..... Codeine or other narcotics?
	Yes	No	..... Other ______________________
9.	Yes	No	Allergy or hay fever?
10.	Yes	No	Sinus trouble?
11.	Yes	No	Asthma, respiratory problems, emphysema, bronchitis, etc.?
12.	Yes	No	Persistent cough or cough that produces blood?
13.	Yes	No	Do you use tobacco products? If so, what kind and frequency:______________
14.	Yes	No	Fainting spells or seizures?
15.	Yes	No	Low blood pressure?
16.	Yes	No	Persistent diarrhea or recent weight loss?
17.	Yes	No	Stomach ulcer or hyper acidity
18.	Yes	No	Have you had abnormal bleeding?
19.	Yes	No	Do you have any blood disorder, such as anemia?
20.	Yes	No	Diabetes?
21.	Yes	No	Hepatitis, jaundice, or liver disease?
22.	Yes	No	Problems of the immune system?
23.	Yes	No	AIDS or HIV infection?
24.	Yes	No	Sexually transmitted disease?

25. Yes No Thyroid problems?

26. Yes No Arthritis or painful swollen joints?
27. Yes No Any artificial joints?
28. Yes No Kidney trouble?
29. Yes No Tuberculosis?
30. Yes No Persistent swollen glands in neck?
31. Yes No Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease?
32. Yes No Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?
    Yes No ..... Do you have chest pain upon exertion?
    Yes No ..... Are you ever short of breath after mild exercise or when lying down?
    Yes No ..... Do your ankles swell?
    Yes No ..... Do you have inborn heart defects?
    Yes No ..... Do you have a cardiac pacemaker?
33. Yes No Epilepsy or other neurological disease?
34. Yes No Problems with mental health?
35. Yes No Cancer?
36. Yes No Have you ever had any treatment for a tumor or growth?
37. Yes No Are you wearing contact lenses?
38. Yes No Are you wearing removable dental appliances?
39. Yes No Have you had any serious trouble associated with any previous dental treatment? If so, explain.

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40. Yes No Do you have any disease, condition, or problem not listed above that you think we should know about? If so, explain.

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WOMEN

19. Yes No Do you have any problems associated with your menstrual period?
21. Yes No Are you taking birth control pills?
18. Yes No Are you pregnant?
20. Yes No Are you nursing?

Chief Dental Complaint:

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Informed Consent:

I understand that any medical or dental treatment cannot offer a guarantee toward any particular or desired result and may have inherent risks associated with each procedure such as tooth loss, nerve damage, infection or temporomandibular dysfunction (TMD/TMJ).
I certify that I have read and understand the above and have answered the questions truthfully. I acknowledge 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.

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Signature of Patient

Medical History Update:

Date	Comments	Signature of Patient