MEDICAL HISTORY

NAME ____ DATE:______________

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

For the following questions, please circle YES or NO, whichever applies.

Your answers are for our records only and will be confidential.
PLEASE CIRCLE ANY QUESTIONS YOU DO NOT UNDERSTAND OR TO WHICH YOU DO NOT KNOW THE ANSWER.

Address: ______________________________
____
____

Birth date: ______________

1. The name and address of your physician is:____
2. Are you in good health? .... YES NO
3. Has there been any change in your general health within the past year? .... YES NO
4. Are you now under the care of a physician? .... YES NO
   a. If so, what is the condition being treated? ____
5. My last physical examination was on (Date).. YES NO
6. Have you had any serious illnesses? .... YES NO
   a. If so, what were they? ____
7. Have you been hospitalized or had an operation in the last two years? .... YES NO
   a. If so, what was the problem? ____
8. Do you have or have you had any of the following diseases or problems?
   a. Heart murmur, Mitral Valve Prolapse, rheumatic fever................................ YES NO
   b. Artificial heart valve.. YES NO
   c. Cardiovascular disease.. YES NO
      i. Angina.. YES NO
      ii. Heart attack.. YES NO
      iii. Irregular heart beat.. YES NO
      iv. High blood pressure.. YES NO
      v. Stroke.. YES NO
      vi. Pacemaker.. YES NO
      vii. Arteriosclerosis (hardening of the arteries)................................ YES NO
         1. Do you have pain in chest upon exertion? .... YES NO
         2. Are you ever short of breath after mild exercise?........................ YES NO
         3. Do your ankles swell? .... YES NO
         4. Do you get short of breath when you lie down? .... YES NO
         5. Do you require extra pillows when you sleep? .... YES NO
   d. Prosthetic joint replacement (hip, knee, shoulder, etc.)................................ YES NO
   e. Allergies.. YES NO
   f. Sinus trouble.. YES NO
   g. Asthma or hay fever.. YES NO
   h. Fainting spells or seizures.. YES NO
   i. Diabetes.. YES NO
   j. Hepatitis or jaundice.. YES NO
   k. Liver disease.. YES NO
   l. Inflammatory rheumatism (painful swollen joints)................................ YES NO
   m. Arthritis.. YES NO

PLEASE TURN OVER

n. Stomach ulcers……………………………………………………………......... YES NO
o. Kidney trouble……………………………………………………...................... YES NO
p. Tuberculosis.. YES NO
q. Do you have a persistent cough or cough up blood? .... YES NO

9. Have you had abnormal bleeding associated with previous extractions or surgery? … YES NO
a. Do you bruise easily? .... YES NO
b. Have you ever required a blood transfusion? .... YES NO
c. Do you have any blood disorder, such as anemia………………………………….. YES NO

10. Is there any history of disease that runs in your family? ……………………………… YES NO
a. If so, please explain ____

11. Have you had treatment for a tumor or growth? ……………………………………… YES NO
a. If so, explain ____

12. Are you taking any drugs or medicine? ………………………………………………….. YES NO
a. If so, what? ____

13. Are you now taking any of the following or have you taken any of these medications, for longer than a 2 week period, in the past 2 years?
a. Antibiotics …..…………………………………………………………………….. YES NO
b. Anticoagulants (blood thinners) …………………………………………………… YES NO
c. Medicine for high blood pressure …………………………………………………. YES NO
d. Cortisone (steroids) ……………………………………………………………….. YES NO
e. Tranquilizers ……………………………………………………………………… YES NO
f. Antihistamines …………………………………………………………………….. YES NO
g. Aspirin ……………………………………………………………………………….. YES NO
h. Insulin ……………………………………………………………………………… YES NO
i. Other medicine for diabetes ……………………………………………………......... YES NO
j. Digitalis or drugs for heart trouble ………………………………………………… YES NO
k. Nitroglycerin ……………………………………………………………………..... YES NO
l. Oral Contraceptive or other hormonal therapy ……………………………………. YES NO
m. Other ____

14. Are you allergic to or have you reacted adversely to:
a. Local anesthetics ………………………………………………………………. YES NO
b. Penicillin or other antibiotics ……………………………………………………… YES NO
c. Aspirin ……………………………………………………………………………….. YES NO
d. Codeine or other narcotics ………………………………………………………… YES NO
e. Other (sulfites, adrenalin, nuts, foods, __etc.) ____________________________________

15. Have you had any serious trouble associated with any previous dental treatment? …… YES NO
a. If so, please explain ____

16. Do you have any disease, condition or problem not listed above that we should know about? ………………………………………………………………………………………. YES NO
a. If so, please explain ____

17. Are you pregnant? ……………………………………………………………….. YES NO

18. Are you nursing? ………………………………………………………………… YES NO

Signature of Patient: ____________________________ Signature of Dentist: ___________________________