MEDICAL HISTORY

PATIENT NAME		TODAY'S DATE
MEDICAL ALERT ❑ Yes ❑ No	PRE-MEDICATE ❑ Yes ❑ No	REASON TO PRE-MEDICATE

Welcome! So that we may provide you with the best possible care, please complete both sides of this form. All information is completely confidential. Please answer each question.

Please Check Yes or No. If Yes, please fill in details. — Yes / No

1. Are you in good health now? ❑ ❑
2. Are you under the care of a physician? ❑ ❑
3. Date of last physical exam was ________________________________
4. Have you ever been hospitalized or had a serious illness? ❑ ❑
   If yes, when and explain ________________________________
5. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now then previously? ❑ ❑
6. (Women) Are you pregnant? If yes, give due date ________________________________ ❑ ❑
7. (Women) Are you breast feeding? ❑ ❑
8. Do you use tobacco in any form? If yes, what and how much ________________________________ ❑ ❑
9. Do you use alcoholic beverages (more than 2 drinks per day)? ❑ ❑
10. Have you lost or gained more than 10 pounds in the past year? ❑ ❑
11. Does your physician require you to take special medication before dentistry? ❑ ❑
    If yes, what and why ________________________________
12. Do you wear contact lenses? ❑ ❑
13. **Please Check Yes or No if you have or have ever had any of the following.**

GENERAL	Yes	No
Tire easily, weakness	❑	❑
Night sweats	❑	❑
Persistent fever	❑	❑
SKIN		
Eruptions (rash) hives	❑	❑
Changes in skin color	❑	❑
EYES		
Visual change	❑	❑
Glaucoma	❑	❑
EARS		
Loss of hearing	❑	❑
Ringing in ears	❑	❑
NOSE		
Frequent nosebleeds	❑	❑
Sinus problems	❑	❑
THROAT		
Soreness/hoarseness	❑	❑
NERVOUS SYSTEM		
Stroke	❑	❑
Headaches	❑	❑
Convulsions/epilepsy	❑	❑
Numbness/tingling	❑	❑
Psychiatric treatment	❑	❑

RESPIRATORY	Yes	No
Tuberculosis	❑	❑
Emphysema	❑	❑
Asthma/hay fever	❑	❑
Persistent Cough	❑	❑
Sputum production (phlegm)	❑	❑
Cough up bloody sputum	❑	❑
Difficulty breathing while lying down	❑	❑
ENDOCRINE		
Diabetes	❑	❑
Family history of diabetes	❑	❑
Thyroid condition/goiter	❑	❑
HEART/BLOOD VESSELS		
Rheumatic fever	❑	❑
Heart murmur	❑	❑
Chest pain/discomfort	❑	❑
Heart attack/trouble	❑	❑
Shortness of breath	❑	❑
Swelling of ankles	❑	❑
High blood pressure	❑	❑
Congenital heart disease	❑	❑
Artificial heart valve	❑	❑
Pacemaker	❑	❑
Heart surgery	❑	❑

BONE MUSCLES	Yes	No
Arthritis/rheumatism	❑	❑
Artificial joints	❑	❑
DIGESTIVE SYSTEM		
Hepatitis	❑	❑
Jaundice	❑	❑
Ulcers	❑	❑
Change in appetite	❑	❑
URINARY		
Kidney disease	❑	❑
Increase in frequency of urination (night)	❑	❑
Burning on urination	❑	❑
Urethral discharge	❑	❑
Bloody urine	❑	❑
Venereal disease	❑	❑
BLOOD		
Bruise easily	❑	❑
Anemia	❑	❑
Blood transfusion	❑	❑
Clotting problems	❑	❑
OTHER		
Radiation therapy	❑	❑
Tumors or growths	❑	❑
Cancer	❑	❑
A.I.D.S.	❑	❑
H.I.V. Positive	❑	❑
Other ________________________________		

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14. Are you ALLERGIC or have you ever experienced any reaction to the following?

	Yes	No
Local anesthetics (e.g. novocaine)	❑	❑
Barbiturates/sedatives/sleeping pills	❑	❑
Penicillin/other antibiotics	❑	❑
Aspirin or codeine	❑	❑
Latex	❑	❑
Sulfa drugs	❑	❑

Other allergies ________________________

15. Are you taking any of the following?

	Yes	No
Antibiotics/sulfa drugs	❑	❑
Blood thinners	❑	❑
Blood pressure medication	❑	❑
Thyroid medicine	❑	❑
Cortisone/steroids	❑	❑
Antihistamines/allergy drugs/ cold remedies	❑	❑
Tranquilizers	❑	❑
Insulin/other diabetes drugs	❑	❑
Recreational drugs	❑	❑
Digitalis/other heart medications	❑	❑
Nitroglycerin	❑	❑
Aspirin	❑	❑
Antidepressants	❑	❑

Other Medication ______________________

If yes to any of the above, list name of medication and dosage below:

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

16. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain ____________________

____

Physician's Name ____________________ Phone ____________________

Address ____________________ City ____________ State ________ Zip __________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completing this form.

Patient/Guardian Signature **X** ____________________ Date ____________

DOCTORS NOTES ON HEALTH HISTORY

Blood Pressure ____________

Pulse ____________

Dentist Signature ____________________ Date ____________________

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