# Medical History Form Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Number, Street

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sex: M F Height \_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_ Single \_\_\_\_\_\_\_\_ Married \_\_\_\_\_\_\_\_

 mo. day yr.

Name of Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Closest Relative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are completing this form for another person, what is your name and relationship to that person? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following questions, *circle yes or no*, and give a detailed explanation for the answer when applicable. 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. 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) is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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6. Have you had any serious illness, operation, 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), vitamins, or herbal treatments? …………………………….…..….……….………. Yes No

 If so, what are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

1. Artificial joints ---------------------------------------------------------------------------------------------------------------------- Yes No
2. 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 inborn heart defects? ---------------------------------------------------------------------------------------- Yes No
5. Do you have a cardiac pacemaker? --------------------------------------------------------------------------------------- Yes No

 d. Allergy ------------------------------------------------------------------------------------------------------------------------------- Yes No

 e. Sinus trouble ------------------------------------------------------------------------------------------------------------------------- Yes No

 f. Asthma or hay fever ---------------------------------------------------------------------------------------------------------------- Yes No

 g. Fainting spells or seizures----------------------------------------------------------------------------------------------------------- Yes No

 h. Persistent diarrhea or recent weight loss ----------------------------------------------------------------------------------------- Yes No

 i. Diabetes ------------------------------------------------------------------------------------------------------------------------------- Yes No

 j. Hepatitis, jaundice or liver disease ------------------------------------------------------------------------------------------------ Yes No

 k. AIDS or HIV infection ------------------------------------------------------------------------------------------------------------- Yes No

 l. Thyroid problems -------------------------------------------------------------------------------------------------------------------- Yes No

 m. Respiratory problems, emphysema, bronchitis, etc. --------------------------------------------------------------------------- Yes No

 n. Arthritis or painful swollen joints ------------------------------------------------------------------------------------------------ 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 glands in neck -------------------------------------------------------------------------------------------------- Yes No

 t. Low blood pressure ------------------------------------------------------------------------------------------------------------------ Yes No

 u. Sexually transmitted disease ------------------------------------------------------------------------------------------------------- Yes No

 v. Epilepsy or other neurological disease -------------------------------------------------------------------------------------------- Yes No

 w. Problems with mental health ------------------------------------------------------------------------------------------------------- Yes No

 x. Cancer --------------------------------------------------------------------------------------------------------------------------------- Yes No

 y. Problems of the immune system --------------------------------------------------------------------------------------------------- Yes No

9. Have you had abnormal bleeding? ---------------------------------------------------------------------------------------------------- Yes No

 a. Have you ever required a blood transfusion? ----------------------------------------------------------------------------------- Yes No

10. Do you have any blood disorders such as anemia? -------------------------------------------------------------------------------- Yes No

11. Have you ever had any treatment for a tumor or growth? ------------------------------------------------------------------------ Yes No

 If so, what kind of treatment was given? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. 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. Other ……………………………………………………………………………………………………………….. Yes No

13. Have you had any serious trouble associated with any previous dental treatment? ------------------------------------------- Yes No

 If so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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14. Do you have any disease, condition, or problem not listed above that you think we should know about? ---------------- Yes No

 If so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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15. Are you wearing contact lenses? --------------------------------------------------------------------------------------------------- Yes No

16. Are you wearing removable dental appliances? ---------------------------------------------------------------------------------- Yes No

17. Do you use controlled substances? ------------------------------------------------------------------------------------------------- Yes No

18. Do you use tobacco (smoking, snuff, chew, bidis)? ----------------------------------------------------------------------------- Yes No

 If so, how often and are you interested in stopping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. Do you drink alcoholic beverages? ------------------------------------------------------------------------------------------------ Yes No

 If yes, how much do you typically drink in a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Women

20. Are you pregnant? -------------------------------------------------------------------------------------------------------------------- Yes No

21. Do you have any problems associated with your menstrual period? ---------------------------------------------------------- Yes No

22. Are you nursing? --------------------------------------------------------------------------------------------------------------------- Yes No

23. Are you taking birth control pills or hormonal replacement?------------------------------------------------------------------- Yes No

**Chief Dental Complaint** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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NOTE: Both health care provider and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Signature of Patient Date

## Other Comments:

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### Signature of Dentist Date