MEDICAL HISTORY FORM

Name: ________________________________ Date: ____________________________________
Date of Birth: __________________________ Sex M / F Height: ____________ Weight: ________________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ……………………………………………………………………..…...............YES / NO
2. Has there been any change in your health in the past year? ………………………………...……………..…..YES / NO
3. My last physical exam was on __________/__________/__________
4. Are you under the care of a physician? ……………………………………………………………………..YES / NO
If so, for what condition? ____
5. The name and address of my physician is: _________________________________
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6. ***Have you ever been diagnosed with a developmental disability?*** ………………………………………..……...YES / NO
7. Have you had any serious illness, significant operation or hospitalization within the past 5 years? ....YES / NO
8. ***Have you had joint replacement surgery*** (such as: knee, hip, etc) within the past 5 years?......................................YES / NO
9. Are you taking any medication(s) including non-prescription, homeopathic or "natural" remedies including diet pills? …………………..………………………………………………………………………..…...................YES / NO
If so, please list: ____
10. Do you have or have had any of the following diseases or problems?
a. High blood pressure, arteriosclerosis (high cholesterol) ....YES / NO
b. Damaged heart valves, artificial valves or heart murmur ……………………………………………….......YES / NO
c. Rheumatic Heart Disease …………………………………………………………………………….........YES / NO
d. Heart trouble, Angina, Stroke, heart attack, or any other heart conditions? ....YES / NO
1. Chest pain upon exertion? ....YES / NO
2. Shortness of breath after mild exercise? ....YES / NO
3. Do your ankles swell? …………………………………………...…..YES / NO

e. Allergies ………………………………YES / NO
f. Asthma or hay fever …………………..YES / NO
g. Diabetes: Type I or II?..........................YES / NO
h. Frequent or recurring mouth sores……YES / NO
i. Stomach ulcer or hyperacidity ………...YES / NO
j. Kidney trouble ………………………....YES / NO
k. Cancer …………………………………YES / NO
r. Sinus trouble ....YES / NO
s. Fainting spells or seizures …..……..…..................YES / NO
t. Hepatitis, jaundice or liver disease ....YES / NO
u. Thyroid disease (hypo /hyper) …………………........YES / NO
v. Tuberculosis..………………….……...………........YES / NO
w. Low blood pressure ....YES / NO
x. persistent swollen neck glands ....YES / NO
l. Respiratory problems, emphysema, bronchitis, COPD etc …………………………………………….........YES / NO
m. Arthritis or painful, swollen joints including jaw joint (TMJ) …………………………………………........YES / NO
n. Persistent cough or cough that produces blood ……………………………………………………….........YES / NO
o. Epilepsy or neurological disorder ……………………………………………...…...YES / NO
p. Any disease, drug or transplant operation that has depressed your immune system …………………................YES / NO
q. Sexually transmitted disease(s) ………………………………………………...…...YES / NO

11. Have you had abnormal bleeding? ……………………………………………...…..YES / NO
a. Have you ever required a blood transfusion? ……………………………………...…...................................YES / NO
12. Do you have any blood disorder such as anemia? …………………………………………………………........YES / NO
13. Have you ever had treatment for a tumor or growth? ……………………………………………………........YES / NO
14. Do you have a history of sleep apnea? Do you currently use a CPAP machine?...YES / NO
15. Are you currently taking or have you taken these medication(s) in the past: Bisphosphonate therapy such as; Fosamax, Boniva, Zometa, Aclasta, Reclast ………………………………………………………………….....YES / NO

16. ***Are you allergic to or have you had a reaction to***:

a. Local anesthetics …... ....…………………………………….…..…..YES / NO
b. Penicillin or antibiotics ……………………………………….……..…...YES / NO
c. Sulfa drugs ……………………………………….……...…...YES / NO
d. Barbiturates or sleeping pills ……………………………………….……...…...YES / NO
e. Aspirin ……………………………………….……...…..YES / NO
f. Iodine ……………………………………….……...…...YES / NO
g. Codeine or other narcotics ……………………………………….……...…...YES / NO
h. Latex or rubber products ……………………………………….……...…..YES / NO
i. Other ……………………………………….……...…..YES / NO

17. Have you had any serious trouble associated with previous dental treatment? ……………...………..……….…...YES / NO
If so, explain: ____

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18. Do you have any other condition or disease you think the doctor should know about? ……………..…………..…YES / NO
If so, explain: ____
19. Are you wearing contact lenses? ……………………………………………………………………….............YES / NO
20. Are you wearing removable dental appliances? ………………………………………………………….…...…YES / NO

Women:
21. Are you pregnant or trying to become pregnant? ………………………………………………………….......YES / NO
22. Do you have problems associated with your menstrual period? ……………………………………….…………....YES / NO
23. Are you nursing? ……………………………………………………………………………………….........YES / NO
24. Are you taking birth control pills? ……………………………………………………………………………..YES / NO

IF YOU ARE USING ORAL CONTRACEPTIVES IT IS IMPORTANT YOU UNDERSTAND THAT **ANTIBIOTICS & OTHER MEDICATIONS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES.** THEREFORE, YOU WILL NEED TO USE MECHANICAL FORMS OF BIRTH CONTROL FOR ONE COMPLETE CYCLE OF BIRTH CONTROL PILLS AFTER THE COURSE OF ANTIBIOTICS OR OTHER MEDICATIONS IS COMPLETED. PLEASE CONSULT WITH YOU PHYSICIAN FOR FURTHER GUIDANCE.

IF YOU ARE PREGNANT, POSSIBLY PREGNANT, OR TRYING TO BECOME PREGNANT, SURGERY ANESTHETIC OR ANY OTHER MEDICATION MAY SIGNIFICANTLY HARM THE DEVELOPMENT OF YOUR BABY, ESPECIALLY DURING THE FIRST TRIMESTER. PLEASE ADVISE THE DOCTOR IF THERE IS ANY CHANCE OF YOUR BEING PREGNANT!

Chief dental complaint: ____

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

Date: ______________Patient/Guardian Signature ____Staff:_______________

Date: ______________Patient/Guardian Signature ____Staff:_______________

Date: ______________Patient/Guardian Signature ____Staff:_______________

Medical History Review Notes:
Date:

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