(PLEASE FILL OUT BOTH SIDES)

Medical History

Date of Birth ______________________________

Patient Name: ____

Address____City/State/Zip_____________________________

Physician's Name: _____________________________________ Phone:_________________________________

Address: ____City/State/Zip_____________________________

Previous Dentist's Name: ________________________ City/State_______________Phone:_________________

Please answer the following by circling yes or no and filling in blanks where indicated:

	A. General Information		
1	Have there been any changes in your health in the last 2 years?	Yes	No
2	Have you been hospitalized or had surgery in the last 2 years? For what_______________	Yes	No
3	Are you now under the care of a physician? Reason_______________________ Date of Last Exam_________________	Yes	No
4	Are you now under the care of a dentist? Reason________________________ Date of Last Visit_________________	Yes	No
5	Are you on a pain contract or under supervision for ongoing pain?	Yes	No
6	Are you under treatment or supervision for substance abuse?	Yes	No
	B. Central Nervous System		
1	Epilepsy, seizures or convulsions?	Yes	No
2	Fainting Spells?	Yes	No
3	Multiple Sclerosis, Cerebral Palsy or Parkinson's?	Yes	No
4	Frequent or severe headaches?	Yes	No
5	Neurological Disorders?	Yes	No
	C. Musculo-Skeletal System		
1	Arthritis, rheumatism, swollen joints?	Yes	No
2	Back or neck pain?	Yes	No
3	Joint Replacement? Date of Surgery__________ Which joint?	Yes	No
	D. Gastrointestinal System		
1	Stomach ulcers / esophageal ulcers?	Yes	No
2	Frequent heartburn / acid reflux?	Yes	No
3	Liver disease / Jaundice?	Yes	No
	E. Urinary System		
1	Kidney Disease / dialysis / transplant?	Yes	No
	F. Endocrine System		
1	Diabetes? Type_______ When Diagnosed_____________ Last HBA1C__________ Date of Last HBA1C__________	Yes	No
2	Thyroid Disease?	Yes	No
3	Other?____	Yes	No
	G. Respiratory System		
1	Emphysema/COPD	Yes	No
2	Chronic Bronchitis / Chronic Cough	Yes	No
3	Sinus Problems	Yes	No
4	Asthma? Date of last episode___________________ Inhaler__________________________________ What triggers attacks?___________________________	Yes	No
	H. Cardiovascular System		
1	Rheumatic fever / Rheumatic heart disease?	Yes	No
2	Heart valve problem / mitral valve prolapse?	Yes	No
3	Artificial heart valve?	Yes	No
4	Pacemaker / Defibrillator	Yes	No
5	Congenital heart disease?	Yes	No
6	History of endocarditis?	Yes	No
7	Heart murmur?	Yes	No
8	Heart attack? Last attack________________________	Yes	No
9	Angina?	Yes	No
10	Stroke / TIA? Last attack	Yes	No
11	High blood pressure?	Yes	No
12	Other?______________________________________	Yes	No
	I. Hematologic System		
1	Anemia?	Yes	No
2	Leukemia?	Yes	No
3	Hemophilia / bleeding problems?	Yes	No
4	Bruise easily?	Yes	No
5	Aspirin therapy?	Yes	No
6	Blood thinners? Last INR ___________ Date___________	Yes	No
	J. Immune System		
1	Allergies? ___________________________________	Yes	No
2	Latex allergy?	Yes	No
3	Autoimmune disease?__________________________	Yes	No
4	Cold sores / canker sores / fever blisters?	Yes	No
	K. Are you allergic or have you have a bad reaction to:		
1	Local anesthetics?	Yes	No
2	Penicillin or other antibiotics?	Yes	No
3	Sulfa drugs?	Yes	No
4	Barbiturates / sedatives / sleeping pills?	Yes	No
5	Aspirin / acetaminophen / ibuprofen?	Yes	No
6	Codeine / Demerol / or other narcotics______________	Yes	No
7	Metals?	Yes	No
8	Other?______________________________________	Yes	No
	L. Oncology		
1	Lump, growths or tumors?	Yes	No
2	Treatment for cancer with surgery, radiation or chemo? Type of cancer__________________Date of last treatment_______________	Yes	No
	M. Bacterial/Viral Conditions		
1	Venereal Disease? Type _________________________	Yes	No
2	AIDS or HIV? When diagnosed____________________	Yes	No
3	Hepatitis? Type______ When diagnosed_____________	Yes	No
4	Tuberculosis?	Yes	No
	N. Sensory System		
1	Eye disorder? (such as glaucoma, macular degeneration, cataracts or blindness)	Yes	No
2	Hearing aid / hard of hearing?	Yes	No
	O. Personal Well-Being		
1	Depression?	Yes	No
2	Anxiety?	Yes	No
3	Dementia / Alzheimer's?	Yes	No
4	Psychiatric condition?	Yes	No
5	Drug or alcohol addiction?	Yes	No
6	Eating Disorder?	Yes	No
7	Mental limitations / Physical limitations?	Yes	No

	P. Are you taking any of the following:		
1	Antibiotics or sulfa drugs?	Yes	No
2	Blood pressure medications?	Yes	No
3	Tranquilizers?	Yes	No
4	Insulin or medication for diabetes?	Yes	No
5	Aspirin?	Yes	No
6	Digitalis or drugs for heart condition?	Yes	No
7	Nitroglycerin?	Yes	No
8	Cortisone (steroids)?	Yes	No
9	Natural remedies / supplements?	Yes	No
10	Other over-the-counter medications?	Yes	No
11	Recreational drug use?	Yes	No
Q.	Is there any medication that your doctor has prescribed that you are **NOT** taking?	Yes	No
R.	Have you ever taken prescription weight loss medications? (such as fen-phen, Redux, etc)	Yes	No
S.	Do you take medications for pain or discomfort?	Yes	No
T.	Have you ever taken prescription medications for osteoporosis? (such as Boniva, Fosamax, Actonel, Aredia or Zometa)	Yes	No
U.	Do you currently (or previously) use tobacco products? Cigarettes a day____________________ Number of years tobacco used______________ When did you quit?________________________	Yes	No
	V. Women		
1	Birth Control or other hormones?	Yes	No
2	Pregnant? Due Date_____________________________	Yes	No
3	Nursing?	Yes	No

Please list medications and reason for taking them

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered the questions to the best of my knowledge. I understand that should additional information be needed, the dental care provider may request this information from the respective heath care provider or agency, and this information may be needed before dental care treatment can begin. I agree to notify the dental care provider of any change in my health or medications.

Patient Signature: ____Date:____________________________

Signature of Parent or Guardian: ____Print Name:____________________________________

Relationship to Patient:____

Dental Provider Signature:____Date:____________________________

Medical history reviewed with patient & health changes or new medications noted below:

Date: ______Health/Med Change: ____

Patient Signature____ Dental Provder:____

Date: ______Health/Med Change: ____

Patient Signature____ Dental Provder:____

Date: ______Health/Med Change: ____

Patient Signature____ Dental Provder:____