Medical History

Patient Name: _________________ _________________ ____
Last First MI

Please answer if you are completing this form for another person. ____________________________ _______________
Your Name Relationship

Medical Information

For the following questions, please (x) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. 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. This information is vital to provide appropriate care for you. This office does not use this information to discriminate.

Yes No

☐ ☐ Are you in good health?
Date of last physical examination ____ /____/ ____

☐ ☐ Has there been any change in your general health within the past year?
If yes, please explain. ____

☐ ☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years?
If yes, please explain. ____

☐ ☐ Are you now under the care of any physicians?

Doctor's Name ______________________ Specialty ________________ Phone (____)_____-__________
Address ________________________ _____ ____________________ _____ __________
Street Suite # City State Zip Code
What is/are the conditions being treated?____

Medications-Are you taking or have you recently taken any of the following drugs?

Yes	No		Name	Yes	No		Name
☐	☐	Antibiotics	_______________	☐	☐	Diet drugs	_______________
☐	☐	Sulfa drugs	_______________	☐	☐	Insulin / other diabetes drugs	_______________
☐	☐	Blood thinners	_______________	☐	☐	Digitalis / other heart drugs	_______________
☐	☐	Blood pressure drugs	_______________	☐	☐	Nitroglycerin	_______________
☐	☐	Thyroid medicine	_______________	☐	☐	Aspirin	_______________
☐	☐	Cortisone / steroids	_______________	☐	☐	Other medications	_______________

Allergies-Are you allergic to or have you had a reaction to any of the following substances?

Yes	No		Yes	No	
☐	☐	Local anesthetics	☐	☐	Latex
☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Penicillin or other antibiotics	☐	☐	Hay fever/seasonal
☐	☐	Sulfa drugs	☐	☐	Animals
☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	Food (specify)
☐	☐	Codeine or other narcotics	☐	☐	Other (Specify) ____________

If yes, specify the type of reaction:____

See Other Side

Conditions-Have you or do you have any of the following diseases or problems? (*Requires Premedication)

Yes	No	Condition
☐	☐	Abnormal bleeding
☐	☐	AIDS or HIV infection
☐	☐	Alcoholism
		If yes, have you received treatment? ☐ Yes ☐ No
☐	☐	Anemia
☐	☐	Arthritis (Degenerative)
☐	☐	Arthritis (Rheumatoid)
☐	☐	Asthma
☐	☐	Blood transfusion
		If yes, date ___/____/____
☐	☐	Cancer/chemotherapy/radiation treatment
☐	☐	Cardiovascular disease
		If yes, indicate below:
		☐ Angina
		☐ Arteriosclerosis
		☐ Artificial heart valves*
		☐ Coronary insufficiency
		☐ Coronary occlusion
		☐ Damaged heart valves
		☐ Mitral valve prolapse*
		☐ Rheumatic heart disease*
		☐ Heart Attack
		☐ Heart Murmur
		☐ Functional
		☐ Nonfunctional*
		☐ High Blood Pressure
		☐ Inborn heart defects
		☐ Pacemaker
☐	☐	Chest pain upon exertion
☐	☐	Chronic pain
☐	☐	Diarrhea (persistent)
☐	☐	Diabetes
		If yes, specify below:
		☐ Type I (Insulin dependent)
		☐ Type II
☐	☐	Drug Dependency
		If yes, have you received treatment? ☐ Yes ☐ No
☐	☐	Dry mouth
☐	☐	Eating disorder
		If yes, specify ___________________________
☐	☐	Epilepsy
☐	☐	Fainting spells or seizures

Yes	No	Condition
☐	☐	Hemophilia
☐	☐	Glaucoma
☐	☐	Hepatitis, jaundice or liver disease
☐	☐	Immunosuppression (disease, drug or radiation-induced)*
☐	☐	Infections (recurrent)
		Indicate type of infection ____________________
☐	☐	Kidney problems
☐	☐	Low blood pressure
☐	☐	Mental health disorders
		If yes, specify ______________________
☐	☐	Malnutrition
☐	☐	Migraines
☐	☐	Night sweats
☐	☐	Neurological disorders
		If yes, specify_______________________
☐	☐	Osteoporosis
☐	☐	Persistent swollen glands in neck
☐	☐	Respiratory problems
		If yes, specify below
		☐ Emphysema
		☐ Bronchitis
☐	☐	Severe, consistent headaches
☐	☐	Severe or rapid weight loss
☐	☐	Sexually transmitted disease
☐	☐	Sinus trouble
☐	☐	Sleep disorder
☐	☐	Sores or ulcers in the mouth
☐	☐	Stroke (cerebral)
☐	☐	Systemic Lupus Erythematosus
☐	☐	Tobacco (smoking, chewing, snuff) use
		If yes, are you interested in stopping? ☐ Yes ☐ No
☐	☐	Thyroid problems
☐	☐	Tuberculosis
☐	☐	Ulcers (intestinal)
☐	☐	Excessive urination

(Women Only)

Yes	No	Question
☐	☐	Are you pregnant?
☐	☐	Are you nursing?
☐	☐	Are you taking birth control pills?

If you have any disease, condition, or problem not already listed, please explain. ____

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I certify that I have read and understand the above. 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/Legal Guardian **Date**