STEVEN E. NAUSS, D.D.S.

MEDICAL HISTORY

Name ______________________ Date ___/___/___ Home Phone (   ) ______________

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. Have you had any serious illness, operation or hospitalization? .... Yes No
   If so, what was the illness or problem? When?
   ____
   ____
4. 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
   b. 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
   c. Allergy (Seasonal) .... Yes No
   d. Sinus trouble .... Yes No
   e. Asthma, hay fever, use inhaler .... Yes No
   f. Fainting spells or seizures .... Yes No
   g. Persistent diarrhea or recent weight loss .... Yes No
   h. Diabetes .... Yes No
      1. Slow-healing cuts .... Yes No
      2. Frequent thirst .... Yes No
      3. Frequent urination (more than 6 times/day) .... Yes No
      4. Increase in appetite with no weight gain .... Yes No
   i. Hepatitis, jaundice or liver disease .... Yes No
   j. AIDS or HIV Infection .... Yes No
   k. Sexually transmitted disease .... Yes No
      (such as syphilis, gonorrhea)
   l. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
   m. Arthritis or painful swollen joints .... Yes No
   n. Stomach ulcer or hyperacidity .... Yes No
   o. Kidney trouble .... Yes No
   p. Tuberculosis .... Yes No
   q. Persistent cough or cough that produces blood .... Yes No
   r. Persistent swollen glands in neck .... Yes No
   s. Low blood pressure .... Yes No
   t. Thyroid Problems .... Yes No
   u. Joint replacement .... Yes No
   v. Epilepsy or other neurological disease .... Yes No
   w. Problems with mental health, stress .... Yes No
   x. Cancer .... Yes No
   y. Problems of the immune system .... Yes No
5. Have you had abnormal bleeding? .... Yes No
   a. Have you ever required a blood transfusion? .... Yes No
6. Do you have any blood disorder such as anemia? .... Yes No
7. Have you ever had any treatment for a tumor or growth? .... Yes No
8. Are you allergic or have you had a reaction to:
   a. Local anesthetics? Novocaine, Lidocaine .... Yes No
      Or any numbing medications? .... Yes No
   b. Penicillin? .... Yes No
   c. Sulfa drugs? .... Yes No
   d. Other antibiotics? .... Yes No
   e. Barbiturates, sedatives, or sleeping pills? .... Yes No
   f. Aspirin? .... Yes No
   g. Iodine? .... Yes No
   h. Codeine or other narcotics? .... Yes No
   i. Other? .... Yes No
9. a. Eye disorders such as glaucoma .... Yes No
   b. Are you wearing contact lenses? .... Yes No
10. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
    If so, explain ______________________
    ____
    ____
11. The name and address of my physician(s) is:
    ____
    ____
    ____
12. My last physical examination was on ______________________
13. Are you now under the care of a physician? .... Yes No
    If so, what is the condition being treated? ______________________
    ____
    ____
14. Are you taking any medicine(s) including non-prescription medicine or birth-control pills? .... Yes No
    If so, what medicine(s) are you taking ______________________
    ____
    ____
    ____
15. Have you had all childhood immunizations? .... Yes No
16. Date of your last Tetanus booster ______________________
17. Are you taking prescription or OTC diet pills? .... Yes No
18. WOMEN: Are you pregnant? .... Yes No
19. Height: __________ Weight: __________

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______________________ Signature of Patient / Legal Guardian

______________________ Signature of Dental Assistant