# Medical History

Today's Date _____

Patient's Name: _____

Circle One: Dr. Mr. Mrs. Ms. Miss Date of Birth_____

(Residence) Street _____ Telephone Number_____

City _____ State _____ Zip Code _____

Occupation _____

Patient Employed by _____

Street _____ Telephone Number_____

City _____ State _____ Zip Code _____

Spouse's (or Parent's) Name _____

(Residence) Street _____ Telephone Number_____

City _____ State _____ Zip Code _____

Social Security Number _____

Whom may we thank for this referral? _____

What prompted you to seek dental care at this time? _____

_____

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**In 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 general health within the past year? ..... Yes No

**3.** Date of your last physical examination? _____

**4.** Are you now under the care of a physician?..... Yes No

If so, what is the condition being treated? _____

**5.** Name and address of your physician: _____

_____

_____

**6.** Have you been hospitalized or had a serious illness within the past five (5) years? ..... Yes No

If so, what was the illness or operation?_____

**7.** Do you have or have you ever had any of the following diseases or problems?.....

**a.** Damaged heart valves or artificial heart valves, including heart murmur..... Yes No

1. Do you have a history of rheumatic fever? ..... Yes No

2. Have you been told you have mitral valve prolapse?..... Yes No

**b.** Do you have any artificial joints (hip replacement, etc.)? ..... Yes No

**c.** Have you ever been told that you need to be premedicated for any dental procedures?..... Yes No

**d.** Congenital heart lesions?..... Yes No

**e.** Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke) If so what ..... Yes No

**1.** Do you have a cardiac pacemaker?..... Yes No

**2.** High blood pressure?..... Yes No

**3.** Low blood pressure?..... Yes No

(over)

**f.** Sinus trouble..... Yes No
**g.** Fainting spells or seizures ..... Yes No
**h.** Diabetes..... Yes No
1. Does your mouth frequently become dry? Yes No
**i** Hepatitis, jaundice or liver disease..... Yes No
**j.** Arthritis ..... Yes No
**k.** Inflammatory rheumatism (painful swollen joints) Yes No
**l.** Stomach ulcers..... Yes No
**m.** Kidney trouble..... Yes No
**n.** Tuberculosis ..... Yes No
**o.** Epilepsy ..... Yes No
**p.** Psychiatric problems..... Yes No
**q.** Cancer..... Yes No
**r.** HIV or AIDS..... Yes No
**s.** Herpes ..... Yes No
**t.** Others _____

**8.** Have you had any abnormal bleeding associated with previous extractions, surgery, or trauma?..... Yes No

**9.** Do you have any blood disorder such as anemia?.. Yes No

**10.** Have you had a surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck? ..... Yes No

**11.** Are you currently taking any drug or medication? If so what? _____ Yes No
_____

**a.** Antibiotics..... Yes No
**b.** Anticoagulants (blood thinners)..... Yes No
**c.** Medicine for high blood pressure..... Yes No
**d.** Aspirin..... Yes No
**e.** Oral contraceptive or other hormonal therapy..... Yes No
**f.** Cortizone (Steroids)..... Yes No
**g.** Other _____ Yes No

**12.** Are you allergic or have you reacted adversely to:
**a.** Local anesthetics ..... Yes No
**b.** Penicillin ..... Yes No
**c.** Other antibiotics ..... Yes No
**d.** Sulfa drugs ..... Yes No
**e.** Aspirin ..... Yes No
**f.** Iodine ..... Yes No
**g.** Codeine or other narcotics..... Yes No
**h.** Other _____

**13.** Do you have any history of alcohol or drug dependencies ..... Yes No

**14.** Have you had any trouble associated with previous dental treatment?..... Yes No
If so explain _____
_____

**15.** Do you have any disease, condition, or problem not listed above that you think I should know about?..... Yes No
If so explain _____
_____

**16.** Are you employed in any situation which expose you regularly to x-rays or other ionizing radiations? ..... Yes No

**17.** Are you wearing removable dental appliances?..... Yes No

**Women**

**18.** Are you pregnant? ..... Yes No

**19.** Are you nursing?..... Yes No

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 other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form . I also understand that the dentist will be relying on the accuracy of this information in determining the course of my treatment.

_____

Signature of patient