Medical History Form

Date _____

Name _____ Email _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Business Phone (____) _____ Cell Phone (____) _____

Occupation _____ Social Security # _____

Date of Birth ____/____/____ ☐Male ☐Female Height _____ Weight _____

☐Single ☐Married ☐Widowed ☐Divorced Name of Spouse _____

Closest Relative _____ Phone (____) _____

If completing this form for another person, what is your relationship to that person? _____

What pharmacy do you prefer? _____

Who were you referred by? _____

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

1) Are you in good health? ☐Yes ☐No
2) Has there been any change in your health within the past year? ☐Yes ☐No
3) My last physical examination was on _____
4) Are you under the care of a physician? ☐Yes ☐No

   If yes, what is the condition being treated? _____
5) The name and address of my physician(s) is _____

   _____
6) Have you had a serious illness, operation, or been hospitalized in the past 5 years? ☐Yes ☐No

   If so, what was the illness or problem? _____
7) Are you taking medicine(s) including non-prescription medicine? ☐Yes ☐No

   If yes, what medicine(s) are you taking? _____

   _____
8) Are you allergic or have you had a reaction to:
   a) Local anesthetics ☐Yes ☐No
   b) Penicillin or other antibiotics ☐Yes ☐No
   c) Sulfa drugs ☐Yes ☐No
   d) Barbiturates, sedatives, or sleeping pills ☐Yes ☐No
   e) Aspirin ☐Yes ☐No
   f) Latex ☐Yes ☐No
   g) Codeine or other narcotics ☐Yes ☐No
   h) Other ☐Yes ☐No
9) Have you had abnormal bleeding? ☐Yes ☐No
   a) Have you ever required a blood transfusion? ☐Yes ☐No
10) Do you have any blood disorders such as anemia? ☐Yes ☐No
11) Have you ever had a treatment for a tumor or growth? ☐Yes ☐No

12) 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 cardiac pacemaker? ☐Yes ☐No
c) Allergy ☐Yes ☐No
d) Sinus trouble ☐Yes ☐No
e) Asthma or hay fever ☐Yes ☐No
f) Fainting spells or seizures ☐Yes ☐No
g) Persistent diarrhea or recent weight loss ☐Yes ☐No
h) Diabetes ☐Yes ☐No
i) Hepatitis, jaundice or liver disease ☐Yes ☐No
j) AIDS or HIV infection ☐Yes ☐No
k) Thyroid problems ☐Yes ☐No
l) Respiratory problems such as 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) A persistent cough or cough that produces blood ☐Yes ☐No
r) Persistent swollen glands in neck ☐Yes ☐No
s) Low blood pressure ☐Yes ☐No
t) Sexually transmitted disease ☐Yes ☐No
u) Epilepsy or other neurological disease ☐Yes ☐No
v) Problems with mental health ☐Yes ☐No
w) Cancer ☐Yes ☐No
x) Problems with immune system ☐Yes ☐No
y) Are you being treated for osteo-penia or osteoporosis? ☐Yes ☐No

13) Have you had any serious trouble associated with any previous dental treatment? ☐Yes ☐No

If yes, explain _____

14) Do you have any disease, condition, or problem not listed above that you think I should know about? ☐Yes ☐No

If yes, explain _____

15) Are you wearing contact lenses? ☐Yes ☐No
16) Are you wearing removable dental appliances? ☐Yes ☐No
17) Do you smoke? ☐Yes ☐No

If yes, how much and how long? _____

18) Have you ever smoked? ☐Yes ☐No

If yes, how much and how long? _____

19) Do you use any other forms of tobacco? ☐Yes ☐No

If yes, what and how long? _____

Women

20) Are you pregnant? ☐Yes ☐No
21) Do you have any problems associated with your menstrual period? ☐Yes ☐No
22) Are you nursing? ☐Yes ☐No
23 Are you taking birth control pills? ☐Yes ☐No

24) What is your 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 other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature of Patient/Guardian _____

For completion by the dentist

Comments on patient interview concerning medical history: _____

_____

Date _____ Signature of Dentist _____