Medical History Form

Date _____

Name _____ Date of Birth _____
Last First Middle

Sex: Male ☐ Female ☐

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

For the following questions, *circle 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 general health within the past year? Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? Yes No
5. The name and address of my physician(s) is _____

_____

_____

6. Have you had any serious illness, operation, or been hospitalized in the past 6 years? Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s), including non-prescription medicine? Yes No
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial valves, including 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 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, 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. 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
9. Are you currently using any tobacco products? Yes No
10. Do you have a history of tobacco usage? Yes No
11. Have you had abnormal bleeding? Yes No
    a. Have you ever required a blood transfusion? Yes No
12. Do you have a blood disorder such as anemia? Yes No
13. Have you ever had any treatment for a tumor or growth? Yes No

14. 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. Iodine Yes No
    g. Codeine or other narcotics Yes No
    h. Latex Yes No
    i. Other write on line
15. Have you had any serious trouble associated with any previous dental treatment? Yes No
    If so, explain:
16. Do you have any disease, condition, or problem not listed above that we should know about? Yes No
    If so, explain:
17. Are you wearing contact lenses? Yes No
18. Are you wearing removable dental appliances? Yes No
19. Have you had a Full Mouth Series or Panoramic Radiographs exposed within the last 3 years? Date:
20. Have you had your Third Molars (Wisdom Teeth) removed? Yes No
21. Have you had orthodontic treatment (Braces)? Yes No
22. Have you had treatment for Periodontal (Gum) problems? Yes No
23. Have you had treatment for TMJ (Jaw Pain)? Yes No

WOMEN

24. Are you pregnant? Yes No
25. Do you have any problems associated with your menstrual period? Yes No
26. Are you nursing? Yes No
27. Are you taking birth control pills? Yes No

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 member of staff, responsible for any errors or omissions that I may have made in the completion of this form.

(Signature of Patient)

For completion by Dentist

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

(Date) (Signature of Dentist)

Medical history update:

Date	Comments	Signature