Medical History Form

Date ______________

Name ______________________ Home Phone ______________

Address ______________________ Cell Phone ______________

City ______________ State ______________ Zip ______________

Occupation ______________________ SSN ______________

Date of Birth ______________ Sex: M or F Height ________ Weight ______________

Name of Spouse ______________ Closest Relative ______________

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

Name of your dentist? ______________________

Name of your physician? ______________________ Phone # ______________

Date of last physical exam?

List all medications you are now taking (include vitamins, laxatives, and birth control pills):

____

____

Do you have any allergies? No / Yes

Drugs ______________

Foods ______________

Other ______________

1. Are you in good health?.. Yes No
2. Has there been any change in your general health within the last year?................................ Yes No
3. Are you now under the care of a physician?.. Yes No

   If so, what is the condition being treated? ______________________
4. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No

   If so, what was the illness or problem? ______________________
5. Are you taking any medicine(s) including non-prescription medicine?.................................. Yes No

   If so, what medicine(s) are you taking? ______________________
6. Are you taking any recreational drugs (marijuana, cocaine, etc?)…………………………… Yes No
7. Do you have or have you had any of the following diseases or problems?........................... Yes No

   a) Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease?... Yes No

   b) Knee or hip replacement, plastic or artificial arteries?... Yes No

   c) Congenital heart defect or murmur?.. Yes No

   d) 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
      6. Do you have an arrhythmia or an irregular heart beat?.. Yes No

   e) Has your physician ever told you to take antibiotics prior to dental therapy for a medical condition? If yes, why?.. Yes No

____

____

7. Do you have or have you had any of the following diseases or problems?........................... Yes No

f) Respiratory disease………………………………………………………………………… Yes No

1. Ashthma, Bronchitis, Pneumonia, Emphysema, Tuberculosis (TB)……….……….. Yes No

2. Chronic cough…………………………………………………………………………… Yes No

3. Hayfever, sinus trouble, allergies……………………………………………………… Yes No

4. Do you smoke? Yes / No Packs per day? How many years?................... Yes No

5. Do you currently have a cold or flu?.. Yes No

g) Diabetes…………………………………………………………………………………… Yes No

h) Persistent diarrhea or recent weight loss……………………………………………… Yes No

i) Hepatitis, jaundice or liver disease…………………………………………………… Yes No

j) AIDS or HIV…………………………………………………………………………… Yes No

k) Fainting spells or seizures…………………………………………………………… Yes No

l) Thyroid problems……………………………………………………………………… Yes No

m) Arthritis or painful swollen joints……………………………………………………… Yes No

n) Stomach ulcer or hyperacidity………………………………………………………… Yes No

o) Kidney trouble………………………………………………………………………… Yes No

p) Persistent swollen glands in neck…………………………………………………… Yes No

q) Low blood pressure…………………………………………………………………… Yes No

r) Sexually transmitted disease………………………………………………………… Yes No

s) Epilepsy………………………………………………………………………………… Yes No

t) Problems with mental health………………………………………………………… Yes No

u) Cancer…………………………………………………………………………………… Yes No

v) Problems of the immune system……………………………………………………… Yes No

8. Do you have a history of alcoholism or drug dependence?.. Yes No

9. How much alcohol do you drink per day averaged over the week?...................................... Yes No

10. Do you bleed easily, bruise easily, or have you had abnormal bleeding with previous treatment?.. Yes No

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

12. Have you had surgery or x-ray treatment for a tumor, growth on your head or neck?......... Yes No

13. Are you allergic or have you reacted adversely to: ………………………………………… Yes No

☐ Local anesthetic	☐ Sedatives	☐ Sleeping pills	☐ Iodine
☐ General anesthetic	☐ Valium	☐ Aspirin	☐ Penicillin or other antibiotics
☐ Sulfa drugs	☐ Demerol	☐ Advil	☐ Morphine
☐ Barbiturates	☐ Codeine	☐ Ibuprofen	☐ Other

14. Have you had any serious trouble associated with any previous dental treatment, surgery or any previous anesthetic? If so, explain……………………… Yes No

____

____

15. Has anyone in your family had a bad reaction to any anesthetic?...................................... Yes No

16. Do you have any disease, condition or problem not mentioned above? If so, explain……. Yes No

____

____

17. Are you wearing contact lenses?.. Yes No

18. Are you able to walk without assistance?.. Yes No

19. Do you use a wheelchair?.. Yes No

20. Will you allow the doctor to start an IV prior to you receiving sedation/anesthesia?........... Yes No

Women

21. Are you now or is there any possibility that you are pregnant?... Yes No

22. Are you nursing?.. Yes No

23. Do you have any problems with your menstrual period?.. Yes No

24. Are you taking birth control pills?... Yes No

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed this health history carefully and have answered all questions truthfully to the best of my knowledge.

______________________________ ______________________________

Signature of Patient or Guardian Date