Medical History

Patient Name_____ Date _____

In the following questions, check yes or no, whichever applies. All information is strictly confidential.

1. Has there been any change in your general health within the past year? ..... YES ☐ NO ☐
2. Your last physical examination was on _____
3. Are you now under the care of a physician? ..... YES ☐ NO ☐
   If so, what is the condition being treated? _____
4. The name and address of your physician is _____
5. Have you had any serious illnesses or operations? ..... YES ☐ NO ☐
6. Have you been hospitalized or had a serious illness within the past five (5) years? ..... YES ☐ NO ☐
   If so, what was the problem? _____
7. Does your physician require you to take antibiotics prior to dental treatment? ..... YES ☐ NO ☐
8. 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 ..... YES ☐ NO ☐
   b. Congenital heart lesions ..... YES ☐ NO ☐
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... YES ☐ NO ☐
      1. Do you have pain in the chest upon exertion? ..... YES ☐ NO ☐
      2. Are you ever short of breath after mild exertion? ..... YES ☐ NO ☐
      3. Do your ankles swell? ..... YES ☐ NO ☐
      4. Do you get short of breath when you lie down such that you require extra pillows during sleep? .. YES ☐ NO ☐
      5. Do you have a cardiac pacemaker? ..... YES ☐ NO ☐
   d. Bleeding disorder or increased clotting time ..... YES ☐ NO ☐
   e. Allergy if so, list: _____ ..... YES ☐ NO ☐
   f. Sinus trouble ..... YES ☐ NO ☐
   g. Asthma or hay feve ..... YES ☐ NO ☐
   h. Hives or skin rash ..... YES ☐ NO ☐
   i. Cancer ..... YES ☐ NO ☐
   i. Diabetes ..... YES ☐ NO ☐
      1. Do you have to urinate (pass water) more than six times a day? ..... YES ☐ NO ☐
      2. Are you thirsty much of the time? ..... YES ☐ NO ☐
      3. Does your mouth frequently become dry? ..... YES ☐ NO ☐
   k. Kidney trouble ..... YES ☐ NO ☐
   l. Liver disease including Hepatitis or Jaundice ..... YES ☐ NO ☐
   m. Stomach ulcers ..... YES ☐ NO ☐
   n. Arthritis ..... YES ☐ NO ☐
   o. Inflammatory rheumatism (painful swollen joints) ..... YES ☐ NO ☐
   p. Epilepsy ..... YES ☐ NO ☐
   q. Fainting spells or seizures ..... YES ☐ NO ☐
   r. Tuberculosis ..... YES ☐ NO ☐
   s. Do you have persistent cough or cough up blood? ..... YES ☐ NO ☐
   t. Venereal disease ..... YES ☐ NO ☐
   u. Psychiatric problems ..... YES ☐ NO ☐
   v. AIDS or other immunosuppressive disorders ..... YES ☐ NO ☐
   w. Other _____
9. Are you allergic or have you reacted adversely 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 _____

(Please turn page over to finish)

10. Are you taking any of the following

a. Antibiotics or sulfa drugs ..... YES ☐ NO ☐
b. Anticoagulants (blood thinners) ..... YES ☐ NO ☐
c. Medicine for high blood pressure ..... YES ☐ NO ☐
d. Cortisone (steroids) ..... YES ☐ NO ☐
e. Tranquilizers ..... YES ☐ NO ☐
f. Antihistamines. ..... YES ☐ NO ☐
g. Aspirin. ..... YES ☐ NO ☐
h. Insulin, Tolbutamide (Orinase) or similar drug ..... YES ☐ NO ☐
i. Digitalis or drugs for heart trouble ..... YES ☐ NO ☐
j. Nitroglycerin ..... YES ☐ NO ☐
k. Oral contraceptive or other hormonal therapy ..... YES ☐ NO ☐
l. Over the counter medications. ..... YES ☐ NO ☐
m. Other _____

11. Have you had any serious trouble associated with any previous dental treatment? ..... YES ☐ NO ☐

If so, explain _____

_____

12. Do you have any disease, condition, or problem not listed above that you think I should know about?. YES ☐ NO ☐

If so, explain _____

_____

13. Have you had surgery, x-ray or drug treatment for a tumor, growth, or condition of head or neck?.... YES ☐ NO ☐
14. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?.. YES ☐ NO ☐
15. Are you wearing contact lenses? ..... YES ☐ NO ☐
16. Do you smoke or use tobacco? ..... YES ☐ NO ☐
17. Is there a family history of diabetes, heart disease, high blood pressure, obesity, or high cholesterol? . YES ☐ NO ☐
18. Have you been diagnosed with sleep apnea? ..... YES ☐ NO ☐

If so, how is it being treated and is the treatment successful? _____

_____

Women

19. Are you pregnant? ..... YES ☐ NO ☐
If so, what trimester? _____
20. Are you nursing? ..... YES ☐ NO ☐
21. Do you have any problems associated with your menstrual period? ..... YES ☐ NO ☐
22. Are you taking birth control medication or hormone replacement medication? ..... YES ☐ NO ☐

I certify that I have read and understand the above, I acknowledge that my questions, if any, about the inquires 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 thisform.

x_____ **x**_____

Signature - Patient **Signature - Provider**

Other pertinent providers

Signature – Provider / Date: _____ **BP / Date:** _____

Signature – Provider / Date: _____ **BP / Date:** _____

Signature – Provider / Date: _____ **BP / Date:** _____