Medical History

Name ______________________________ Date __________

Last First Middle

Address ______________________________

and Street City State Zip

Date of Birth __________ Sex __________ Height __________ Weight __________ Occupation __________

Single __________ Married __________ Spouse __________ Phone # __________

Closest relative ______________________________ Phone # __________

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

____

When applicable for the following questions, circle yes or no, which ever applies. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past year .... YES NO
2. My last physical examination was ______________________________
3. Are you currently under the care of a physician .... YES NO
4. Name and address of my physician ______________________________
5. Have you had any serious illness or operation .... YES NO
   a. If so, what was the problem ______________________________
6. Have you been hospitalized or have you had a serious illness with in the past 5 years .... YES NO
   a. If so, what was the problem ______________________________
7. Do you have or have you had any of the following diseases or conditions:
   a. Rheumatic fever or rheumatic heart disease .... YES NO
   b. Congenital heart lesions and/or a heart murmur .... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke .... YES NO
      – Do you have chest pain upon exertion .... YES NO
      – Are you ever short of breath after mild exercise .... YES NO
      – Do your ankles swell .... YES NO
      – Do you get short of breath when you lie down, or require extra pillows when you sleep .... YES NO
   d. Allergies .... YES NO
   e. Sinus trouble .... YES NO
   f. Asthma or hay fever .... YES NO
   g. Hives or a skin rash .... YES NO
   h. Fainting spells or seizures .... YES NO
   i. Diabetes .... YES NO
   j. Hepatitis, jaundice or liver disease .... YES NO
   k. Arthritis .... YES NO
   l. Inflammatory rheumatism (painful swollen joints) .... YES NO
   m. Stomach ulcers .... YES NO
   n. Kidney trouble .... YES NO
   o. Tuberculosis .... YES NO
   p. Persistent cough or cough up blood .... YES NO
   q. Low blood pressure .... YES NO
   r. Venereal disease .... YES NO
   s. HIV/AIDS .... YES NO

8. Have you had abnormal bleeding associated with previous extractions, surgeries, or traumas .... YES NO
   a. Do you bruise easily .... YES NO
   b. Have you ever required a blood transfusion .... YES NO
   If so, explain the circumstances ____
9. Do you have any blood disorders such as anemia .... YES NO
10. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips ...... YES NO
11. Are you taking any drugs or medicine (including but not limited to birth control, vitamins, over the counter medicines, etc.) .... YES NO
    a. If so, what ____
12. 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. Bisphosphonates/Osteoporosis medicine .... YES NO
    f. Tranquilizers .... YES NO
    g. Antihistamines .... YES NO
    h. Aspirin .... YES NO
    i. Insulin, tolbutamide (Orinase) or similar drug .... YES NO
    j. Digitalis or drugs for heart trouble .... YES NO
    k. Nitroglycerin .... YES NO
    l. Other ____
13. Are you allergic or have you reacted adversely to any of the following:
    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 products .... YES NO
    i Other ____
14. Have you ever been or are you currently chemically dependent .... YES NO
    Have you ever been or are you currently in a substance recovery program .... YES NO
15. Have you ever had any serious trouble associated with any previous dental treatment............................ YES NO
    a. If so, explain ____
16. Do you have any disease, condition or problem not listed above that you think I should know about .... YES NO
    a. If so, explain ____
17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation .... YES NO
18. Are you wearing contact lenses .... YES NO

WOMEN

19. Are you pregnant .... YES NO
20. Do you have any problems associated with your menstrual cycle .... YES NO

Remarks:

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Signature of Patient