Medical History Form

PERSONAL INFORMATION:

Name:_____ Home Phone ( )_____
Last First Middle

Address:_____ Work Phone ( )_____

City:_____ State:_____ Zip:_____ Cell Phone ( )_____

Social Security #:_____ Date of Birth:_____ Sex: M F Height:_____ Weight:_____
Marital Status: □ Single □ Married □ Divorced □ Widowed

Name of Spouse:_____ Closest Relative _____ Phone ( )_____

If you are completing this form for another person, what is your relationship to that person?_____
Would you like appointment reminders via email? Email address _____

EMPLOYEE INFORMATION:

Occupation:_____ Employer Name _____

SUBSCRIBER (Sub) INFORMATION

Insurance Company:_____ Group No:_____ ID:_____
Subscriber's Name:_____ Sub Social Security #:_____ Sub DOB:____/____/____

REFERRAL INFORMATION:

Were you referred to this office by: Family_____ Friend_____ Doctor_____ Other_____

What brings you to this dental office today?_____

For the following questions, *please circle **YES or NO***, whichever applies. Your answers are for our records and will be considered confidential. Please note that during initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions about your health.

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. Your last physical examination was on _____ ___and last dental visit was _____
4. Are you now under the care of a physician?..... Yes No
   If so, what is the condition(s) being treated_____
   _____
   _____
5. The name and address of your physician is_____
   _____
6. Have you ever had any serious illness, operation, or been hospitalized in the past five years?..... Yes No
7. Are you currently taking any medications, including prescription and non-prescription medicine?..... Yes No

If so, please list all medications, dosages, and how frequently you take the medication.

	Medication	Dosage	Frequency		Medication	Dosage	Frequency
1.				4.			
2.				5.			
3.				6.			

8. Do you take aspirin, Ecotrin, Coumadin, or any other blood thinner on a regular basis?..... Yes No
9. Do you 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 on exertion?..... Yes No

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2. Are you ever short or breath after mild exercise or when lying down? Yes No
3. Do you ankles swell? Yes No
4. Do you have inborn health 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 the 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 of the immune system? Yes No

10. Do you currently smoke? Yes No
11. Do you have any history of alcohol or substance abuse? Yes No
12. Have you ever had abnormal bleeding? Yes No
13. Do you have any blood disorder such as anemia? Yes No
14. Have you ever had any treatment for a tumor or growth? Yes No
15. Have you ever had a joint replacement surgery? Yes No
16. 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. Other? Yes No
17. Have you had any serious trouble associated with any previous dental treatment? Yes No
    If so, please explain. _____
18. Do you have disease, condition, or problem not listed above that you think I should know about? Yes No
    If so, please explain. _____
19. Are you wearing contact lenses? Yes No
20. Are you wearing removable dental appliances? Yes No

The next following questions are for the female patient:

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

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 mad in the completion of this form.

_____ _____
Date Signature of Patient

_____ _____
Date Signature of Doctor/Dentist