

**MEDICAL HISTORY FORM**

Name \_\_\_\_\_ Date: \_\_\_\_\_

For the following questions, check 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  
If so, what is the condition being treated? \_\_\_\_\_
5. The name and address of my physician(s) is \_\_\_\_\_  
\_\_\_\_\_
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?  
If so, what was the illness or problem? \_\_\_\_\_
7. Are you taking any medicine(s) including non-prescription medicine?      Yes      No      List all medications \_\_\_\_\_  
\_\_\_\_\_
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 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	
i) Do you have chest pain upon exertion?	Yes	No	
ii) Are you ever short of breath after mild exercise or when lying down?	Yes	No	
iii) Do your ankles swell?	Yes	No	
iv) Do you have a cardiac pacemaker?	Yes	No	
c. Allergies or hayfever	Yes	No	
d. Sinus Trouble	Yes	No	
e. Asthma	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 of the immune system	Yes	No	
9. Have you had abnormal bleeding?      Yes      No
  - a. Have you ever required a blood transfusion?      Yes      No
10. Do you have any blood disorder such as anemia?      Yes      No
11. Have you ever had any treatment for a tumor or growth?      Yes      No
12. Are you allergic or have you had a reaction to:
 

a. Local anesthetics?      Yes      No	f. Aspirin?      Yes      No
b. Penicillin?      Yes      No	g. Iodine?      Yes      No
c. Sulfa drugs?      Yes      No	h. Codeine?      Yes      No
d. Other antibiotics?      Yes      No _____	i. Other narcotics?      Yes      No _____
e. Barbiturates, sedatives, or sleeping pills?      Yes      No	j. Other _____

13. Do you have any disease, condition, or problem not listed above that you think the doctor should know about?    Yes    No  
please explain: \_\_\_\_\_

14. Are you wearing contact lenses?    Yes    No

**Women**

15. Are you pregnant?    Yes    No

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

17. Are you nursing?    Yes    No

18. Are you taking birth control pills?    Yes    No

**Dental**

19. Have you had any serious trouble associated with any previous dental treatment?    Yes    No

20. Are you wearing removable dental appliances?    Yes    No

21. What would you like to change about your smile? \_\_\_\_\_

22. Chief dental concern \_\_\_\_\_

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 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 Updates:**

Date

Comments

Signature

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____