MEDICAL HISTORY FORM

NAME: _____ DATE: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ SEX: M F HEIGHT: _____ WEIGHT: _____
MO DAY YEAR

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

If you are completing this form for someone else, what is your relationship to them? _____

In order to treat you efficiently and effectively, please answer the questions below to the best of your ability. Your answers will be held in the strictest confidence. ***CIRCLE***

1. Are you in good health? ..... Yes No
2. What is your occupation? _____
3. Has there been any change in your general health within the past year? ..... Yes No
4. When was your last physical examination? _____
5. Are you under the care of a physician? ..... Yes No
   If yes, please explain: _____
6. Name of your physician: _____ Phone: (_____)_____
7. Have you had any serious illness, operation, or been hospitalized in the past five years? ..... Yes No
   If yes, please explain: _____
8. Do you smoke / vape / e-cig / JUUL? ..... Cigarettes / Cigars / Pipe / Cannabis? ..... Yes No
   How much and how often? _____
9. Are you taking any medication(s) including non-prescription medicine and vitamins? ..... Yes No
   If yes, what (*including recreational drugs*) are you taking? (please continue on separate page if needed)
   _____
10. Are you now taking or have you ever taken any medication to treat Osteoporosis? ..... Yes No
    If yes, which one and how long? _____
11. Do you have or have you had any of the following diseases or problems? (Please circle an answer for every item)

Damaged Heart Valves	Yes	No	Allergy	Yes	No
Artificial Heart Valves	Yes	No	Sinus Trouble	Yes	No
Rheumatic Fever	Yes	No	Asthma or Hay Fever	Yes	No
Rheumatic Heart Disease	Yes	No	Fainting Spells, Seizures	Yes	No
Heart Murmur	Yes	No	Persistent Diarrhea	Yes	No
Heart Surgery	Yes	No	Diabetes	Yes	No
Heart Attack	Yes	No	Hepatitis, Jaundice, or Liver Disease	Yes	No
Angina	Yes	No	Venereal Disease (Syphilis, Gonorrhea)	Yes	No
Coronary Insufficiency/Heart Failure	Yes	No	AIDS or HIV Infection	Yes	No
Coronary Occlusion	Yes	No	Thyroid Problems	Yes	No
High Blood Pressure	Yes	No	Respiratory Problems, Emphysema, Bronchitis	Yes	No
Low Blood Pressure	Yes	No	Arthritis or painful swollen joints	Yes	No
Arteriosclerosis	Yes	No	Stomach Ulcer or Hyperacidity	Yes	No
Stroke	Yes	No	Kidney Disease	Yes	No
Chest pain upon exertion	Yes	No	Tuberculosis	Yes	No
Do you have genetic heart defects?	Yes	No	Persistent cough or cough that produces blood	Yes	No
Do you wear a cardiac pacemaker?	Yes	No	Persistent swollen glands in the neck	Yes	No
Artificial Joints (Hip, Knee, etc)	Yes	No	Cancer	Yes	No
Drug Addiction	Yes	No	Problems with mental health	Yes	No
Epilepsy or other neurologic disease	Yes	No	Glaucoma	Yes	No
Anemia or other blood problems	Yes	No	Obstructive Sleep Apnea	Yes	No

Please Continue on Reverse Side

12. Have you ever had abnormal bleeding / bleeding disorder? ..... Yes No
13. Have you ever required a blood transfusion? ..... Yes No

    If yes, please explain: _____
14. Are you aware of any trouble starting an IV? ..... Yes No
15. Have you taken any cortisone medications within the last year? ..... Yes No
16. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... Yes No
17. Do your ankles swell during the day? ..... Yes No
18. Do you use more than 2 pillows when you sleep, or do you wake up short of breath? ..... Yes No
19. Have you lost or gained more than 10 pounds within the past year? ..... Yes No
20. Are you on a special diet? ..... Yes No
21. Have you ever had problems with your immune system? ..... Yes No

    If yes, please explain: _____
22. Are you wearing contact lenses? ..... Yes No
23. Are you allergic to or have you reacted adversely to any of the following medications?
    Please Circle all Applicable

Aspirin	Penicillin	Latex Products	Any other Medication or Substance:
Codeine	Erythromycin	Local Anesthetic	_____
Demerol	Tetracycline	Novocain	_____
Nitrous Oxide	Iodine/Shellfish	Xylocaine	_____

24. Do you have any disease, condition, or problem not listed that we should know about? ..... Yes No

    If yes, please explain: _____

WOMEN

25. Are you pregnant? ..... Yes No
26. Do you have any problems associated with your menstrual period? ..... Yes No
27. Are you nursing? ..... Yes No
28. 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 staff, responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Signature of Patient Signature of Dentist

For Office Use Only

I have reviewed my health history and certify that all information is correct. Date:_____ Int:_____

Additions:_____

I have reviewed my health history and certify that all information is correct. Date:_____ Int:_____

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Additions:_____