Medical History Form

Date_____

Name_____
Last First Middle

Name of Closest Relative or Emergency Contact_____
Contact Telephone Numbers Home:_____ Work:_____

Name of **Second** Emergency Contact not living with you _____
Emergency Contact Telephone Numbers Home:_____ Work:_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health?..... Yes No
2. Has there been any change in your health within the past year?..... Yes No
3. My last physical exam was on (approximate date)_____
4. Are you under the care of a physician?..... Yes No
If so, what condition are you being treated for? _____
_____
5. The name, address and phone number of my general physician is _____
_____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
If so, what was the illness or problem? _____
7. Are you taking **any** medicine, herbal or nutritional supplements including non-prescription medication?..... Yes No
If so, what are you taking? _____
_____
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 fever..... Yes No
b. Have you had a joint or valve replacement?..... Yes No
Do you require antibiotic premedication before dental treatment?..... Yes No
c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
1. Do you have chest pain upon exertion?..... Yes No
2. Are you ever short of breath after mild exercise or when lying down?..... Yes No
3. Do your ankles swell?..... Yes No
4. Do you have inborn heart defects?..... Yes No
5. Do you have a cardiac pacemaker?..... Yes No
d. Allergy or hay fever..... Yes No
e. Sinus trouble..... Yes No
f. Asthma ..... Yes No
g. Fainting spells or seizures..... Yes No
h. Persistent diarrhea or weight loss..... Yes No
i. Diabetes..... Yes No
j. Hepatitis, jaundice, or liver disease..... Yes No
k. AIDS or HIV infection..... Yes No
l. Thyroid problems..... Yes No
m. Respiratory problems, emphysema, bronchitis, etc..... Yes No
n. Arthritis or painful swollen joints..... Yes No
o. Stomach ulcer, gastric reflux, or hyperacidity..... Yes No
p. Kidney trouble..... Yes No
q. Tuberculosis..... Yes No
r. Persistent cough or cough that produces blood..... Yes No
s. Persistent swollen glands in your neck..... Yes No
t. Low blood pressure..... Yes No

PLEASE COMPLETE BACK OF FORM

u. Sexually transmitted disease..... Yes No
v. Epilepsy or other neurological disease..... Yes No
w. Problems with mental health or psychiatric treatment..... Yes No
x. Cancer..... Yes No
y. 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 a recovering alcoholic or drug user? Yes No
a. Have you taken any form of methamphetamine or cocaine within the last 24 hours? Yes No

13. Are you allergic or have you had a reaction to:
a. Local anesthetics..... Yes No
b. Antibiotics..... Yes No
If so please list which antibiotics_____
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_____

14. Have you had any serious trouble associated with any previous dental treatment? Yes No
If so, please explain _____
_____

15. Do you have any disease, condition or problem not listed above Yes No
If so, please explain _____
_____

16. Are you wearing contact lenses?..... Yes No

17. Are you wearing removable dental appliances?..... Yes No

18. **Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel®, Fosamax® or Zometa, within the past twelve years?** Yes No

Women

18. Are you pregnant?..... Yes No

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

20. Are you nursing?..... Yes No

21. Are you taking birth control pills?..... Yes No

Chief Dental Complaint_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the above inquires have been answered to my satisfaction.

Printed Name of Patient or Guardian _____**Date**_____

Signature of Patient or Guardian _____ **Date**_____