MEDICAL HISTORY FORM

NAME: _____ **DATE:**_____

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 in the past year? ..... yes no
3. My last physical exam was on _____/ _____ / _____
4. Are you under the care of a physician? ..... yes no
   If so, for what condition? _____
5. The name of my physician is:_____
6. Have you had any serious illness, significant operation or hospitalization within the past 5 years? yes no
7. Are you taking any blood thinners? (If yes, please list _____) yes no
8. Are you taking any other medicine(s)(including nonprescription, homeopathic or "natural" remedies including diet pills?) If so, please list _____ yes no

---

---

9. Do you have or have you had any of the following diseases or problems?
   - **a**. Damaged heart valves, artificial valves or heart murmur - mitral valve prolapse..... yes no
   - **b**. Rheumatic Heart Disease ..... yes no
   - **c**. Rheumatic Fever ..... yes no
   - **d**. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition? ..... yes no
     1. Chest pain upon exertion? ..... yes no
     2. Shortness of breath after mild exercise? ..... yes no
     3. Do your ankles swell? ..... yes no
   - e. Allergies ..... yes no
   - f. Sinus Trouble ..... yes no
   - g. Asthma or hay fever ..... yes no
   - h. Fainting spells or seizures ..... yes no
   - i. Diabetes ..... yes no
   - j. Hepatitis, jaundice or liver disease ..... yes no
   - k. Frequent or recurring mouth sores ..... yes no
   - l. Thyroid problems ..... yes no
   - j. Respiratory problems, emphysema, bronchitis, etc. ..... yes no
   - k. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... yes no
   - l. Stomach ulcer or hyperacidity or colitis ..... yes no
   - m. Kidney trouble ..... yes no
   - n. Tuberculosis ..... yes no
   - o. Persistent cough or cough that produces blood ..... yes no
   - p. Persistent swollen neck glands ..... yes no
   - q. Low blood pressure ..... yes no
   - r. Epilepsy or neurological disorder ..... yes no
   - s. Are you taking vitamins or homeopathic remedies..... yes no
   - t. Cancer ..... yes no
   - **u**. Any disease, drug or transplant operation that has depressed your immune system ..... yes no
10. Have you had abnormal bleeding? ..... yes no
    a. Have you ever required a blood transfusion? ..... yes no
11. Do you have any blood disorder such as anemia? ..... yes no
12. Have you ever had treatment for a tumor or growth? ..... yes no
13. Are you allergic to or have you had a reaction to:
    - a. Local anesthetics ..... yes no
    - b. Penicillin or antibiotics ..... yes no
    - c. Sulfa drugs ..... yes no
    - d. Barbiturates or sleeping pills ..... yes no
    - e. Aspirin ..... yes no
    - f. Iodine ..... yes no
    - g. Codeine or other narcotics ..... yes no
    - h. Latex or rubber products ..... yes no
    - i. Adhesive tape ..... yes no

LIST ANY OTHER DRUGS/MEDICATIONS YOU ARE ALLERGIC TO: _____

_____

14.Do you smoke? If yes, packs per day _____ ..... yes no
15. Do you use snuff, smokeless tobacco or chewing tobacco? ..... yes no
16. Have you had any serious trouble associated with previous dental treatment? ..... yes no
If yes, explain: _____

_____

17. Do you have any other condition or disease you think the doctor should know about yes no
If so, explain: _____
18. Are you wearing contact lenses? ..... yes no
19. Are you wearing removable dental appliances? ..... yes no
20. Do you have implant devices such as eye lens replacements, hip implant, knee replacement or pace maker? ..... yes no
21. Do you wish to talk with the doctor privately about anything? ..... yes no

Women

22. **Are you pregnant or trying to become pregnant?** ..... yes no
23. Do you have problems associated with your menstrual period? ..... yes no
24. Are you nursing? ..... yes no
25. **Are you taking birth control pills?** ..... yes no

Chief Complaint: (Why did you come to see us today?) _____

_____

_____

Verbal History/Review of Systems

ALL:

MEDS:

OPS:

ILL:

ROS: