PATIENT MEDICAL HISTORY FORM

Title _____ First Name _____ Middle_____ Last Name_____

Address_____City_____State_____Zip_____

Home Phone_____Work Phone _____ Ext._____ Pager _____ E-mail _____

Is there anything about your smile that you would like to change? _____

Sex: Male ☐ Female ☐ Height _____ Weight _____ DOB _____ SSN _____

Emergency Contact _____ _Phone _____ **Referred by** _____

Insurance Policy Holder : Name_____DOB_____SSN_____

Employer_____ Employer's Address _____

Dental Insurance Company/Address _____ Group No._____

Your answers to the questions below are for our records only and will be considered confidential. 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 exam was on _____
4. Are you currently under the care of a physician? ..... ☐ Yes ☐ No
   If so, what is the condition being treated? _____
   Name and phone # of physician _____
5. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... ☐ Yes ☐ No
6. Are you taking any medicine(s) including non-prescription medicine?
   If so, what medicine(s) are you taking? _____
   _____
7. Do you now have or have you ever had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur, mitral valve prolapse 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 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
   c. High or low blood pressure? (Circle one)..... ☐ Yes ☐ No
   d. Sinus infections? ..... ☐ Yes ☐ No
   e. Asthma? ..... ☐ Yes ☐ No
   f. Hay fever? ..... ☐ Yes ☐ No
   g. Respiratory problems - emphysema, bronchitis, etc.? ..... ☐ Yes ☐ No
   h. Tuberculosis? ..... ☐ Yes ☐ No
   i. Persistent cough or cough that produces blood? ..... ☐ Yes ☐ No
   j. Fainting spells, seizures, epilepsy, convulsions or other neurological disease? ..... ☐ Yes ☐ No
   k. Persistent diarrhea or recent weight loss? ..... ☐ Yes ☐ No
   l. Diabetes or hypoglycemia? ..... ☐ Yes ☐ No
   m. Hepatitis, jaundice or liver disease? ..... ☐ Yes ☐ No

n. Stomach ulcer or hyperacidity? ☐ Yes ☐ No

o. Kidney trouble? ☐ Yes ☐ No

p. Thyroid problems? ☐ Yes ☐ No

q. Persistent swollen glands in neck? ☐ Yes ☐ No

r. Arthritis or painful swollen joints? ☐ Yes ☐ No

s. Artificial joint replacement? ☐ Yes ☐ No

t. Cold sores, fever blisters, canker-sore in the mouth or on the lips? ☐ Yes ☐ No

u. AIDS or HIV infection? ☐ Yes ☐ No

v. Any sexually transmitted disease - including syphilis, gonorrhea, herpes? ☐ Yes ☐ No

w. Cancer? ☐ Yes ☐ No

x. Problems of the immune system? ☐ Yes ☐ No

y. Drug or alcohol abuse or dependency? ☐ Yes ☐ No

z. Problems with mental health? ☐ Yes ☐ No

15. Do you have frequent headaches, or migraines, or any jaw discomfort? ☐ Yes ☐ No

16. Have you had abnormal bleeding? ☐ Yes ☐ No

17. Have you ever required a blood transfusion? ☐ Yes ☐ No

18. Do you have any blood disorder such as anemia? ☐ Yes ☐ No

19. Do you experience delayed healing from a wound or cut? ☐ Yes ☐ No

20. Have you ever had any treatment for a tumor or growth? ☐ Yes ☐ No

21. Are you allergic or have you had a reaction to:

a. Local anesthetics? ☐ Yes ☐ No

b. Lidocaine/Novocaine? ☐ Yes ☐ No

c. Penicillin, Amoxicillin or other antibiotics? ☐ Yes ☐ No

d. Sulfa drugs? ☐ Yes ☐ No

e. Barbiturates, sedatives or sleeping pills? ☐ Yes ☐ No

f. Aspirin? ☐ Yes ☐ No

g. Iodine? ☐ Yes ☐ No

h. Codeine or other narcotics? ☐ Yes ☐ No

i. Jewelry or other metals? ☐ Yes ☐ No

j. Other _____ ☐ Yes ☐ No

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

23. Do you have any disease, condition, or problem not listed above that you think we should know about?
_____ ☐ Yes ☐ No

24. Are you wearing contact lenses? ☐ Yes ☐ No

25. Are you wearing removable dental appliances? ☐ Yes ☐ No

26. Do you use tobacco products ? ☐ Yes ☐ No

Women:

27. Do you suspect or are you pregnant? ☐ Yes ☐ No

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

29. Are you nursing? ☐ Yes ☐ No

30. Are you taking birth control pills? ☐ Yes ☐ No

I certify that I have read and understand the questions above. Any questions that I had in regards to these questions have been answered to my complete satisfaction. I will not hold my dentist, or any other member of the staff responsible for any errors/omissions that I may have made in completion of this form. I will advise the dental office staff and the dentist of any changes in my physical condition, health history, and/or changes in my medication.

Signature _____ Date _____