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Medical History Form

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FIRST NAME:

LAST NAME:

| | Yes | No | Unknown |
|---|--------------------------|--------------------------|--------------------------|
| 1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has there been any change in your general health within the past year? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under the care of a physician for a current problem? If yes, explain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been hospitalized within the past 5 years? If yes, please specify. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you received therapy for alcoholism or drug addiction during the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is there any condition concerning your health that the doctor should be told? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you wish to speak to the doctor privately about anything? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you had abnormal bleeding with previous extractions, surgeries, or trauma? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had surgery and/or radiation for a tumor, growth, or other condition? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever tested positively for HIV infection or AIDS? If so, date diagnosed and the treating doctor: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you required to take antibiotics prior to dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

14. Have you had any of the following? If yes, please check box below.

| | | | |
|--|--------------------------|---|--------------------------|
| High blood pressure | <input type="checkbox"/> | Sinus trouble | <input type="checkbox"/> |
| Heart murmur or prolapsed valve | <input type="checkbox"/> | Thyroid problems | <input type="checkbox"/> |
| Joint prosthesis (hip, knee, etc.) | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Rheumatic fever/rheumatic heart disease | <input type="checkbox"/> | Stomach ulcers, colitis | <input type="checkbox"/> |
| Congenital heart disease | <input type="checkbox"/> | Hepatitis, jaundice, liver disease | <input type="checkbox"/> |
| Cardiovascular disease | <input type="checkbox"/> | Kidney problems | <input type="checkbox"/> |
| Prosthetic heart valve | <input type="checkbox"/> | Psychiatric treatment | <input type="checkbox"/> |
| Blood disorder (e.g., anemia) | <input type="checkbox"/> | Fainting spells or seizures | <input type="checkbox"/> |
| Venereal disease | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Cancer | <input type="checkbox"/> |
| Allergy to latex | <input type="checkbox"/> | Temporomandibular joint problems (TMJ) | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> | Low blood sugar | <input type="checkbox"/> |
| Chest pain, angina | <input type="checkbox"/> | Dialysis | <input type="checkbox"/> |
| Swollen ankles, arthritis or joint disease | <input type="checkbox"/> | Irregular heart beat | <input type="checkbox"/> |
| Cardiac pacemaker | <input type="checkbox"/> | Contagious diseases | <input type="checkbox"/> |
| Heart surgery | <input type="checkbox"/> | Bronchitis, chronic cough | <input type="checkbox"/> |
| Delay in healing | <input type="checkbox"/> | Hay fever or sinus problems | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | Problems with the immune system | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Difficult breathing or other lung trouble | <input type="checkbox"/> |
| X-ray treatment or chemotherapy | <input type="checkbox"/> | Chronic fatigue or night sweats | <input type="checkbox"/> |
| On a diet | <input type="checkbox"/> | History of drug abuse | <input type="checkbox"/> |
| History of alcohol abuse | <input type="checkbox"/> | Wear contact lenses | <input type="checkbox"/> |
| Eye disease or glaucoma | <input type="checkbox"/> | Bruise easily | <input type="checkbox"/> |
| Infectious mononucleosis | <input type="checkbox"/> | Gallbladder trouble | <input type="checkbox"/> |

| | Yes | No | Unknown |
|---|--------------------------|--------------------------|--------------------------|
| 15. Are you taking any herbal medicine (i.e., St. Johns Wort)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever taken the "fen-phen" diet? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have any disease, condition, or problem not listed above? Specify. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you taking bisphosphonates now or have you in the past? (Fosamax) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Are you taking any medications or drugs? If yes, please list them on the next page : | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please continue on other side.

Please list your medications below:

Women only:

| | | | |
|---------------------------|----------|-----------------------------|----------|
| Possibility of pregnancy: | YES / NO | Nursing: | YES / NO |
| Estimated delivery date: | | Taking birth control pills: | YES / NO |

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

If This visit is related to an injury, fill out the fields below:

| | |
|---|---------------------------------------|
| <input type="checkbox"/> Accident related | <input type="checkbox"/> Work related |
| Date of Injury: | |
| Insurance Company Handling Claim: | |
| Claim Number: | |
| Name of Attorney / Adjustor: | |
| Attorney / Adjustor Telephone #: | |

Physician's Info:

Emergency Contact Info:

| | |
|-------------------|-------------|
| Physician Name: | Name: |
| Physician Phone: | Work Phone: |
| Specialist Name: | Home Phone: |
| Specialist Phone: | |

Patient Signature (Parent signature if patient is under 18 years of age)

Date