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?	☐	☐	☐
2. Has there been any change in your general health within the past year? If yes, please explain.	☐	☐	☐
3. Are you under the care of a physician for a current problem? If yes, explain.	☐	☐	☐
4. Have you been hospitalized within the past 5 years? If yes, please specify.	☐	☐	☐
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?	☐	☐	☐
6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications?	☐	☐	☐
7. Is there any condition concerning your health that the doctor should be told?	☐	☐	☐
8. Do you wish to speak to the doctor privately about anything?	☐	☐	☐
9. Have you had abnormal bleeding with previous extractions, surgeries, or trauma?	☐	☐	☐
10. Have you ever required a blood transfusion?	☐	☐	☐
11. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?	☐	☐	☐
12. Have you ever tested positively for HIV infection or AIDS? If so, date diagnosed and the treating doctor:	☐	☐	☐
13. Are you required to take antibiotics prior to dental treatment?	☐	☐	☐

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

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

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

Please continue on other side.

************<u>Please list your medications below</u>*****************

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:

☐ Accident related	☐ 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:	Home Phone:
Specialist Name:	Work Phone:
Specialist Phone:	

____

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