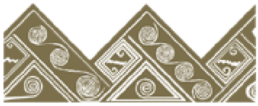

PATIENT MEDICAL HISTORY

Patient's Last Name	First/Middle Initial	Date
Date of Birth (MM/DD/YYYY)	Height	Weight

If you are completing this form for the patient, what is your relationship to the patient? ______________________

For the following questions, please check the boxes *yes* or *no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that 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.

Name/Address/Phone number of my physician(s):______________________

1.	Are you in good health?	Yes	No
2.	Has there been any change in your general health within the last year? Date of my last physical examination: ______________________	Yes	No
3.	Are you under the care of a physician? If yes, please list condition(s) being treated: ______________________	Yes	No
4.	Have you had any serious illness, operation or been hospitalized in the past 5 years? If yes, please list illness or problem(s): ______________________	Yes	No
5.	Are you taking any medication(s) including non-prescription medicine? If yes, please list medication(s) you are taking: ______________________	Yes	No

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

6.	Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease	Yes	No
7.	Cardiovascular disease If yes, please circle the following you have or have had: Heart trouble, Heart attack, Angina, Coronary Insufficiency, Coronary Occlusion, High Blood Pressure, Arteriosclerosis, Stroke	Yes	No
	a. Do you have chest pain upon exertion?	Yes	No
	b. Are you ever short of breath after mild exercise or when lying down?	Yes	No
	c. Do your ankles swell?	Yes	No
	d. Do you have inborn heart defects?	Yes	No
	e. Do you have a cardiac pacemaker?	Yes	No
	f. Do you use tobacco in any form? If yes, how much: ______________________	Yes	No
8.	Allergy	Yes	No
9.	Sinus trouble	Yes	No
10.	Asthma or hay fever	Yes	No
11.	Fainting spells or seizures	Yes	No
12.	Persistent diarrhea or recent weight loss	Yes	No
13.	Diabetes	Yes	No
14.	Hepatitis, jaundice or liver disease	Yes	No
15.	AIDS or HIV infection	Yes	No
16.	Thyroid problems	Yes	No
17.	Respiratory problems, emphysema, bronchitis, etc.	Yes	No
18.	Arthritis or painful swollen joints	Yes	No
19.	Have you had any hip, knee or other joint replacement(s)?	Yes	No
20.	Stomach ulcer or hyperacidity	Yes	No
21.	Kidney trouble	Yes	No
22.	Tuberculosis	Yes	No
23.	Persistent cough or cough that produces blood	Yes	No
24.	Persistent swollen glands in neck	Yes	No

Over

25.	Low blood pressure	Yes	No
26.	Sexually transmitted disease	Yes	No
27.	Epilepsy or other neurological disease	Yes	No
28.	Problems with mental health	Yes	No
29.	Cancer	Yes	No
30.	Problems of the immune system	Yes	No
31.	Have you had abnormal bleeding?	Yes	No
	a. Have you ever required a blood transfusion?	Yes	No
32.	Do you have any blood disorder such as anemia?	Yes	No
33.	Have you ever had any treatment for a tumor or growth?	Yes	No

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

34.	Local anesthetics	Yes	No
35.	Penicillin or other antibiotic? If other(s), please list: ______________________________	Yes	No
36.	Sulfa drugs	Yes	No
37.	Barbiturates, sedatives or sleeping pills	Yes	No
38.	Aspirin	Yes	No
39.	Iodine	Yes	No
40.	Codeine or other narcotics	Yes	No
41.	Latex	Yes	No
42.	Other allergies? If yes, please list: ______________________________	Yes	No
43.	Have you had any serious trouble associated with previous dental treatment? If yes, please explain: ______________________________	Yes	No
44.	Do you have any disease, condition or problem not listed above that you think we should know about? If yes, please explain: ______________________________	Yes	No
45.	Are you wearing contact lenses?	Yes	No
46.	Are you wearing removable dental appliances?	Yes	No
47.	Women: Are you pregnant?	Yes	No
48.	Women: Are you nursing?	Yes	No
49.	Women: Are you taking birth control pills?	Yes	No

What are your major dental concern(s)? ______________________________

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of Patient (or Parent/Legal Guardian)

FOR COMPLETION BY DENTIST ONLY

Comments on patient interview concerning medical history:

____

____

Significant findings from questionnaire or oral interview:

____

____

Dental management considerations:

____

____

______________________________ ______________________________
Date Signature of Dentist

MEDICAL HISTORY UPDATE:

Date	Comments	Signature