MEDICAL HISTORY FORM

Patient's Name:_____ Date:_____

Date of Birth: _____ Sex: M / F ☐ ☐ Height:_____Weight: _____

Answer all questions, by checking yes or no. Answers are kept confidential.

	Yes	No
1. Are you in good health?	☐	☐
2. Has there been any change in your health in the past year?	☐	☐
3. Date of last physical exam was on _____		
4. Are you now under the care of a physician?	☐	☐
If so, for what condition? _____		
5. Physician's name and address:_____		
_____		
6. Have you ever had any serious illness, operation or hospitalization?	☐	☐
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)?	☐	☐
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa or others)?	☐	☐
9. Are you taking any medicine including prescription or non-prescription, vitamins, supplements, diet pills, homeopathic or natural remedies?	☐	☐
Please list: _____		
_____		
10. Do you have or have you had any of the following diseases or problems?		
a. Damaged heart valves, artificial valves or heart murmur	☐	☐
b. Rheumatic Heart Disease or other congenital heart disease	☐	☐
c. Cardiovascular Disease (Heart trouble, heart attack, angina, stroke, arteriosclerosis, high blood pressure, or any other heart condition)?	☐	☐
1. Chest pain or Shortness of breath upon exertion or after mild exercise?	☐	☐
2. Do your ankles swell?	☐	☐
d. Allergies	☐	☐
e. Sinus trouble	☐	☐
f. Asthma or hay fever	☐	☐
g. Fainting spells or seizures	☐	☐
h. Diabetes	☐	☐
i. Hepatitis, jaundice or liver disease	☐	☐
j. Frequent or recurring mouth sores	☐	☐
k. Thyroid problems	☐	☐
l. Respiratory or breathing problems, emphysema, bronchitis, etc.	☐	☐
m. Arthritis or painful, swollen joints including jaw joint (TMJ)	☐	☐
n. Osteoporosis	☐	☐
o. Stomach ulcer or hyperacidity, Reflux	☐	☐
p. Kidney trouble	☐	☐
q. Tuberculosis	☐	☐
r. Persistent cough or cough that produces blood	☐	☐
s. Persistent swollen neck glands	☐	☐
t. Low blood pressure	☐	☐
u. Epilepsy or neurological disorder	☐	☐
v. Cancer	☐	☐
w. Any disease, drug or transplant operation that has depressed your immune system	☐	☐
11. Have you had abnormal bleeding, or do you take a blood thinner?	☐	☐
a. Have you ever required a blood transfusion?	☐	☐

	Yes	No
12. Do you have any blood disorder such as anemia?	☐	☐
13. Have you ever had treatment for a tumor or growth?	☐	☐
14. Have you had radiation therapy to the head, neck or jaws?	☐	☐
15. **Known Drug Allergies:** Are you allergic to or have you had a reaction to:		
a. Local anesthetics	☐	☐
b. Penicillin or antibiotics	☐	☐
c. Sulfa drugs	☐	☐
d. Barbiturates or sleeping pills	☐	☐
e. Aspirin	☐	☐
f. Iodine	☐	☐
g. Codeine or other narcotics	☐	☐
h. Latex or rubber products	☐	☐
i. Other	☐	☐
16. Have you had any serious problems associated with prior dental or surgical treatment?	☐	☐
Please explain:_____		
_____		
17. Do you have any other condition or disease you think the doctor should know about?	☐	☐
Please explain:_____		
18. Do you smoke or chew Tobacco?	☐	☐
How much? _____		
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?	☐	☐
20. Have you or a family member had any problem associated with anesthesia?	☐	☐
21. Are you wearing contact lenses?	☐	☐
22. Are you wearing removable dental appliances?	☐	☐
23. Do you wish to talk with the doctor privately about anything?	☐	☐

Women

20. Are you pregnant or **is there any chance** you might be pregnant?	☐	☐
21. Do you have problems associated with your menstrual period?	☐	☐
22. Are you nursing?	☐	☐
23. Are you taking birth control pills?	☐	☐

Chief Complaint / Reason for your visit: _____

I have read and understand the above. I understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely. I have had the opportunity to discuss my Health History with my doctor. I also authorize the release of any medical or dental information from prior physicians or dentists who have treated me.

Date:_____Patient's Signature:_____

Print

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Management considerations: _____

Date:_____ Doctor's Signature:_____

Medical History Update:

Date	Comments	Signature