MEDICAL HISTORY FORM

Date_____

PERSONAL INFORMATION

Name_____ Home Phone_____

Address_____ Work Phone_____

City_____ State_____ Zip Code_____

Occupation_____ Social Security Number_____

Date of Birth_____ Sex M F Height_____ Weight_____

Marital Status:_____ Name of Spouse_____

Referred by_____

Chief Dental Complaint_____

FOR THE FOLLOWING QUESTIONS, PLEASE CHECK YES OR NO, WHICHEVER APPLIES. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

General Health: EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Last physical:_____ Name and address of physician:_____

Have you had any serious illness, operation or hospitalization within the past 5 years? Yes☐ No☐

Are you taking any medicine(s) including non-prescription? Yes☐ No☐

If so please list_____

Do you have or have you had any of the following diseases or problems?

Damaged or artificial heart valves	Yes☐ No☐	Rheumatic Heart Disease	Yes☐ No☐
Heart trouble, heart attack	Yes☐ No☐	Heart murmur	Yes☐ No ☐
Sinus Trouble	Yes☐ No☐	Asthma	Yes☐ No☐
Diabetes	Yes☐ No☐	Fainting spells	Yes☐ No☐
Hepatitis, jaundice or liver disease	Yes☐ No☐	Tuberculosis	Yes☐ No☐
Arthritis or painful, swollen joints	Yes☐ No☐	Stomach ulcer or hyperacidity	Yes☐ No☐
Kidney trouble	Yes☐ No☐	Angina, stroke, arteriosclerosis	Yes☐ No☐
Cancer	Yes☐ No☐	Abnormal blood pressure	Yes☐ No☐
Epilepsy or neurological disorder	Yes☐ No☐	AIDS or ARC	Yes☐ No☐

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

Are you allergic or have you had a reaction to:

Local anesthetics	Yes☐ No☐		Aspirin	Yes☐ No☐	
Penicillin or antibiotics	Yes☐ No☐		Iodine	Yes☐ No☐	
Sulfa drugs	Yes☐ No☐		Codeine or other narcotics	Yes☐ No☐	
Barbiturates or sleeping pills	Yes☐ No☐		Other_____		

Have you had any serious trouble associated with previous dental treatment? Yes☐ No☐
If so, explain_____

Do you have any other condition or disease you think I should know about? Yes☐ No☐
If so, explain_____

Are you wearing removable dental appliances? Yes☐ No☐

Women

Are you pregnant?	Yes☐ No☐		Are you nursing?	Yes☐ No☐	
Are you taking birth control pills?	Yes☐ No☐				

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

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 member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient/Legal Guardian

FOR COMPLETION BY THE DENTIST

Comments on patient interview concerning medical history_____

Significant findings from questionnaire or oral interview_____

Dental management considerations_____

Notes_____

Date_____ Signature of Dentist_____