PATIENT MEDICAL HISTORY FORM

Date _____

Name_____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code_____ Email _____

Date of Birth _____ Social Security No_____ Sex Male or Female

Married _____ Single _____ Separated_____ Divorced_____ Minor_____ Partnered for _____ Years

Employer Name _____Work Phone_____

Dental Ins. Name _____ ID #_____ Ins. Phone _____

Name of Spouse _____ Phone No._____

Closest Relative _____ Phone No._____

If you are completing this form for another person, what is your relationship to that person _____

Name of person completing this form _____Referred by _____

For the following question, answer 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.

1. Are you in good health?..... □ Yes □ No
2. Has there been any change in your general health within the past year?..... □ Yes □ No
3. My last physical examination was on _____
4. Are you now under the care of a physician? .... Yes □ No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____ _____ _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?.....□ Yes □ No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including nonprescription medicine?.....□ Yes □ No
   if so, what medicine(s) are you taking? _____ _____
8. Do you have or have you had any of the following Diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease.....□ Yes □ No
   b. Cardiovascular disease (heart trouble, heart, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .....□ Yes □ No
      1. Do you have chest pain upon exertion..□ Yes □ No
      2. Are you ever short of breath after mild exercise or when lying down?.....□ Yes □ No
      3. Do your ankles swell? .....□ Yes □ No
      4. Do you have inborn heart defects? .....□ Yes □ No
      5. Do you have a cardiac pacemaker? .....□ Yes □ No
   c. Allergy.....□ Yes □ No
   d. Sinus trouble.....□ Yes □ No
   e. Asthma or hay fever.....□ Yes □ No
   f. Fainting spells or seizures.....□ Yes □ No
   g. Persistent diarrhea or recent weight loss...□ Yes □ No
   h. Diabetes.....□ Yes □ No
   i. Hepatitis, jaundice or liver disease.....□ Yes □ No
   j. AIDS or HIV infection.....□ Yes □ No
   k. Thyroid problems.....□ Yes □ No
   l. Respiratory problems.....□ Yes □ No
   m. Arthritis or painful swollen joints.....□ Yes □ No
   n. Stomach ulcer or hyperacidity.....□ Yes □ No
   o. Kidney trouble.....□ Yes □ No
   p. Tuberculosis.....□ Yes □ No
   q. Persistent cough or cough that produces blood.....□ Yes □ No
   r. Persistent swollen glands in neck.....□ Yes □ No
   s. Low blood pressure.....□ Yes □ No
   t. Sexually transmitted disease.....□ Yes □ No
   u. Epilepsy or other neurological disease.....□ Yes □ No
   v. Problems with mental health.....□ Yes □ No
   w. Cancer.....□ Yes □ No
   x. problems of the immune system.....□ Yes □ No
9. Have you had abnormal bleeding?.....□ Yes □ No
   a. Have you ever required a blood transfusion?.....□ Yes □ No

10. Do you have any blood disorder such as Anemia?..... Yes No

11. Have you ever had any treatment for a tumor or growth?..... Yes No

12. Are you allergic or have you had a reaction to:
    a. Local anesthetics..... Yes No
    b. Penicillin or other antibiotics..... Yes No
    c. Sulfa drugs..... Yes No
    d. Barbiturates, sedatives or sleeping pills..... Yes No
    e. Aspirin..... Yes No
    f. Iodine..... Yes No
    g. Codeine or other narcotics..... Yes No
    h. Other..... Yes No

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

    _____

    _____

14. Do you have any disease, condition, or problem not listed above that you think we should know about? ..... Yes No
    If so, explain_____

    _____

    _____

15. Are you wearing contact lenses?..... Yes No
16. Are you wearing dental removable dental appliances..... Yes No

WOMEN

17. Are you pregnant? ..... Yes No
18. Do you have any problems associated with you menstrual period? ..... Yes No
19. Are you nursing? ..... Yes No
20. Are you taking birth control pills? ..... Yes No

Chief Dental complaint _____

_____

_____

_____

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 of omission that I may have made in the completion of this form. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of Patient or Guardian Date

_____

FOR COMPLETION BY THE DENTIST

Comments of patient interview concerning medical history: _____

_____

_____

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctors Progress notes:

Date	Treatment	Charges
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____