

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Circle Appropriate Answer (leave blank if you do not understand question):

Yes No Is your general health good?
Yes No Have you been hospitalized or had a serious illness in the last three years?
If yes, why? _____
Yes No Are you being treated by a physician now? For what? _____
Date of last medical exam? _____ Current Physician _____

HAVE YOU EXPERIENCED:

Yes	No	Chest pain (angina)			
Yes	No	Shortness of breath	Yes	No	TMJ (jaw joint) problems
Yes	No	Fainting spells or Seizures	Yes	No	Sinus problems
Yes	No	Bleeding problems, bruising easily	Yes	No	Dry Mouth

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	Heart Disease, Heart attack, heart defects			
Yes	No	Heart murmurs or mitral prolapse	Yes	No	Treatment with Steroids or Cortisone
Yes	No	Rheumatic fever	Yes	No	Arthritis
Yes	No	Stroke	Yes	No	Kidney, bladder disease
Yes	No	High Blood Pressure	Yes	No	Thyroid, adrenal disease
Yes	No	Anemia	Yes	No	Diabetes
Yes	No	Stomach problems, ulcers	Yes	No	Hepatitis, other liver disease
Yes	No	Asthma, TB, emphysema, other lung diseases	Yes	No	Allergy to Medications
Yes	No	Immune Disorders			_____
Yes	No	Tumors, cancer			_____

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	Radiation treatments	Yes	No	Allergy to Penicillin
Yes	No	Chemotherapy	Yes	No	Allergy to Latex
Yes	No	Prosthetic heart valve	Yes	No	Blood transfusions
Yes	No	Artificial joint	Yes	No	Pacemaker
			Yes	No	Contact lenses

ARE YOU TAKING:

Yes	No	Recreational drugs	Yes	No	Tobacco in any form?	Amount? _____
Yes	No	Prescription Drugs or over-the-counter medicines	Yes	No	Alcohol?	Amount? _____
Yes	No	Aspirin	Yes	No	Herbal Supplements?	

PLEASE LIST CURRENT MEDICATIONS _____

WOMEN ONLY:

Yes No Are you or could you be Pregnant or Nursing? _____
Yes No Taking Birth Control Pills? _____

ALL PATIENTS:

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so please explain:

Please list all past SURGICAL PROCEDURES _____

Prior HOSPITALIZATIONS: _____

Height _____

Weight _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient _____ Staff _____ Date _____

BP _____

Soft Tissue Exam

Pulse _____

Findings