

# Patient Medical History

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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Emergency Contact Name/Relationship \_\_\_\_\_ Cell # \_\_\_\_\_

Preferred Pharmacy Name/Street \_\_\_\_\_ Phone: \_\_\_\_\_

**Please circle the following answers.**

1. Are you in good health?..... Yes No Don't Know

2. Has there been any change in your health in the last year?..... Yes No Don't Know

If yes, explain: \_\_\_\_\_

3. Have you ever been hospitalized, had a major operation or serious illness?..... Yes No Don't Know

If yes, explain: \_\_\_\_\_

4. Date of your last visit to your doctor? \_\_\_\_\_ Reason for last visit? \_\_\_\_\_

5. Are you currently receiving treatment or regular medical care by your doctor?..... Yes No Don't Know

If yes, for what condition(s)? \_\_\_\_\_

6. Are you taking any of the following **medications** (circle answer and list medication name)?

a. Antibiotics or sulfa drugs..... Yes No Don't Know

b. Anticoagulant (blood thinners) ..... Yes No Don't Know

c. Medicine for high blood pressure..... Yes No Don't Know

d. Cortisone (steroids)..... Yes No Don't Know

e. Tranquilizers..... Yes No Don't Know

f. Antihistamines..... Yes No Don't Know

g. Aspirin..... Yes No Don't Know

h. Insulin, tolbutamide (Orinase) or other drugs for diabetes..... Yes No Don't Know

i. Digitalis or drugs for heart trouble..... Yes No Don't Know

j. Nitroglycerin..... Yes No Don't Know

k. Birth control pills or other hormones..... Yes No Don't Know

l. Pain medications such as Advil, Nuprin, Motrin or Naprosyn..... Yes No Don't Know

m. Synthroid or other thyroid medication..... Yes No Don't Know

n. Phen/Fen..... Yes No Don't Know

o. **Other MEDICATIONS**, please list name only:

\_\_\_\_\_  
\_\_\_\_\_

7. Are you **allergic** to or have you had any unusual reactions to:

a. ANTIBIOTICS ALLERGY (list) \_\_\_\_\_ Yes No Don't Know

b. CODEINE ALLERGY \_\_\_\_\_ Yes No Don't Know

c. OTHER DRUG ALLERGIES (list) \_\_\_\_\_ Yes No Don't Know

d. OTHER NON DRUG ALLERGIES (list) \_\_\_\_\_ Yes No Don't Know

**ARE YOU BEING TREATED BY A DOCTOR FOR THESE: (Circle answer & underline the condition. List medication if applicable)**

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|--|-----|----|------------|
| 8. Damaged heart valves or artificial heart valves, including heart murmur, mitral valve prolapse, rheumatic fever, rheumatic heart disease, or artificial joints or valves..... | Yes | No | Don't Know |
| 9. Congenital heart problems.....  | Yes | No | Don't Know |
| 10. Heart trouble, heart attack, high blood pressure, stroke.....  | Yes | No | Don't Know |
| a. Do you have pain in your chest upon exertion?.....  | Yes | No | Don't Know |
| b. Are you ever short of breath after mild exercise?.....  | Yes | No | Don't Know |
| c. Do your ankles swell?.....  | Yes | No | Don't Know |
| 11. Severe or frequent headaches? Sinus problems?..  | Yes | No | Don't Know |
| 12. Blood disorders such as anemia or hemophilia?..  | Yes | No | Don't Know |
| 13. Breathing problems, emphysema, tuberculosis, or other lung problems? .....   | Yes | No | Don't Know |
| 14. Asthma, hay fever, or hives?....   | Yes | No | Don't Know |
| 15. Stomach or intestinal disease, or ulcers?.....   | Yes | No | Don't Know |
| 16. Cancer, x-ray treatments, or chemotherapy? (List type & if past or existing).....  | Yes | No | Don't Know |
| 17. Diabetes or blood sugar problems? .....  | Yes | No | Don't Know |
| 18. Hepatitis, jaundice, or liver disease? .....   | Yes | No | Don't Know |
| 19. Kidney infections, frequent urination, or renal (kidney) dialysis? .....   | Yes | No | Don't Know |
| 20. Stroke, seizures, fainting spells, numbness, or other neurological problems? .....   | Yes | No | Don't Know |
| 21. Syphilis, gonorrhea, or genital herpes? .....  | Yes | No | Don't Know |
| 22. AIDS, AIDS-related condition, or HIV positive? .....   | Yes | No | Don't Know |
| 23. Tumors or growths? .....   | Yes | No | Don't Know |
| 24. Arthritis or rheumatism? .....   | Yes | No | Don't Know |
| 25. Phobias, severe anxieties, depression, psychoses, unusual fears, or other mental problems? .....   | Yes | No | Don't Know |
| 26. Psoriasis, seborrhea, or other skin diseases? .....  | Yes | No | Don't Know |
| 27. Have you lost weight without dieting or gained weight in recent months? .....  | Yes | No | Don't Know |
| 28. Do you have complaints regarding your eyes, ears, or nose? .....   | Yes | No | Don't Know |

If yes, explain: \_\_\_\_\_

- |  |     |                |            |
|--|-----|----------------|------------|
| 29. Do you wear contact lenses? .....  | Yes | No             | Don't Know |
| 30. Do you now use or have you ever used recreational drugs? .....                                 | Yes | No             | Don't Know |
| 31. How many packs of cigarettes do you smoke per day?.....  | ___ | packs per day  |            |
| 32. How many drinks of beer, wine, or liquor do you drink per day?.....                            | ___ | drinks per day |            |
| 33. <b>For women</b> , are you pregnant or do you think you may be pregnant? .....                 | Yes | No             | Don't Know |
| 34. Have you been diagnosed with <b>sleep apnea</b> ? .....  | Yes | No             | Don't Know |
| 35. Do you have <b>TMJ issues</b> – popping/clicking/pain when chewing, opening/closing, etc?..... | Yes | No             | Don't Know |
| 36. Are there any other problems about your health that you know of? .....                         | Yes | No             | Don't Know |

If yes, describe: \_\_\_\_\_

**SIGNATURE OF PATIENT:** *I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.*

**PERSON COMPLETING THIS FORM:** \_\_\_\_\_ Signature Date \_\_\_\_\_

If other than patient, indicate relationship: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**SUMMARY OF HISTORY AND NOTATION OF SIGNIFICANT FINDINGS BY DOCTOR**

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