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. Synthyroid or other thyroid medication.................................. Yes No Don't Know
   n. High cholesterol .... Yes No Don't Know
   o. Phen/Fen... Yes No Don't Know
   p. **Other MEDICATIONS**, please list name only:

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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

Please see other side

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

Question			
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. **For women**, are you pregnant or do you think you may be pregnant?	Yes	No	Don't Know
34. Have you been diagnosed with **sleep apnea**?	Yes	No	Don't Know
35. Do you have **TMJ issues** – 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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