

Medical History

Name _____ Date _____
Last First Middle

Age _____ Sex _____ Height _____ Weight _____ Occupation _____

Single Married Spouse _____

Birth Date _____ Reported by _____

In the following questions, circle YES or NO, whichever applies.
Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past year? Yes No
2. My last physical exam was on _____
3. Are you now under the care of a physician? Yes No
If yes, what is the condition being treated? _____
4. The name and address of my physician is: _____

5. Do you use tobacco? Yes No
If yes, what type and how often? _____
6. Have you had any serious illness or operation? Yes No
If so, what was the illness or operation? _____
7. Have you ever had joint replacement? Yes No
If yes, when? _____
8. Have you been hospitalized or had a serious illness within the past five (5) years? Yes No
If yes, what was the problem? _____
9. Have you ever been premedicated with antibiotics prior to dental cleaning? Yes No
10. Do you have, or have you had, any of the following diseases or problems?
 - a. Rheumatic fever or rheumatic heart disease, heart murmur Yes No
 - b. Congenital heart lesions Yes No
 - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, mitral valve prolapse) Yes No
 - 1) Do you have pain in chest upon exercise? Yes No
 - 2) Are you ever short of breath after mild exercise? Yes No
 - 3) Do your ankles swell? Yes No
 - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? Yes No
 - d. Allergy Yes No
 - e. Asthma or hay fever Yes No
 - f. Hives or a skin rash Yes No
 - g. Fainting spells or seizures Yes No
 - h. Diabetes Yes No
 - 1) Do you have to urinate (pass water) more than six times a day? Yes No
 - 2) Are you thirsty much of the time? Yes No
 - 3) Does your mouth frequently become dry? Yes No
 - i. Hepatitis, jaundice or liver disease Yes No
 - j. Arthritis Yes No
 - k. Inflammatory rheumatism (painful swollen joints) Yes No
 - l. Stomach ulcers Yes No
 - m. Kidney trouble Yes No

- n. Tuberculosis Yes No
- o. Persistent cough, or coughing up blood Yes No
- p. Low blood pressure Yes No
- q. Venereal disease Yes No
- r. HIV Yes No
- s. Other _____
11. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
- a. Do you bruise easily? Yes No
- b. Have you ever required a blood transfusion? Yes No
- If yes, explain the circumstances: _____
12. Do you have any blood disorder such as anemia? Yes No
13. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips? Yes No
14. Are you taking any drug or medication? Yes No
- If yes, list all: _____
15. Are you taking any of the following:
- a. Antibiotics or sulfa drugs Yes No
- b. Anticoagulants (blood thinners) Yes No
- c. Medicine for high blood pressure Yes No
- d. Cortisone (steroids) Yes No
- e. Tranquillizers Yes No
- f. Aspirin Yes No
- g. Insulin, tolbutamide (Orinase) or similar drug Yes No
- h. Nitroglycerin Yes No
- i. Other: _____
16. Are you allergic or have you reacted adversely 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. Latex Yes No
- h. Other: _____
17. Have you had any serious trouble associated with any previous dental treatment? Yes No
- If yes, explain: _____
18. Do you have any disease, condition or problem not listed above that you think I should know about? Yes No
- If yes, please explain: _____
19. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Yes No

WOMEN:

20. Are you pregnant? Yes No

Signature of Patient

Signature of Dentist