MEDICAL HISTORY FORM

Full Name____ **Date**_________________________

For the following questions, ***Circle 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.

Are you in good health?	Yes No
Has there been any change in your general health within the past year?	Yes No
My last physical examination was_____________________________	
Are you now under the care of a physician?	Yes No
The name & address of my physician is____	
Have you had any serious illness, operation, or been hospitalized in the last 5 years?	Yes No
Are you taking any medicine(s) including nonprescription medicine?	Yes No
If so, what medicines are you taking?____	
Do you have or have you had any of the following conditions?	

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks___
☐	☐	Are you nursing?

Other Conditions:___________________________

Allergies:

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Metals
☐	☐	Dental Anesthetics	☐	☐	Penicillin
☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Jewelry			

Other:____

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Frequent Headaches	☐	☐	Sickle Cell Disease
☐	☐	Alcohol Abuse	☐	☐	Glaucoma	☐	☐	Sinus Problems
☐	☐	Allergies	☐	☐	Hay Fever	☐	☐	Stroke
☐	☐	Anemia	☐	☐	Heart Attack	☐	☐	Thyroid Problems
☐	☐	Angina Pectoris	☐	☐	Heart Surgery	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Hemophilia	☐	☐	Ulcers
☐	☐	Artificial Joints	☐	☐	Hepatitis A or B	☐	☐	Venereal Disease
☐	☐	Artificial Heart Valve	☐	☐	High Blood Pressure	☐	☐	Yellow Jaundice
☐	☐	Asthma	☐	☐	HIV+ AIDS			
☐	☐	Autoimmune Disease	☐	☐	Intestinal Disorders			
☐	☐	Blood Transfusion	☐	☐	Kidney Problems			
☐	☐	Cancer-Chemotherapy	☐	☐	Liver Disease			
☐	☐	Congenital Heart Defect	☐	☐	Low Blood Pressure			
☐	☐	Cosmetic Surgery	☐	☐	Mitral Valve Prolapse			
☐	☐	Diabetes	☐	☐	Pacemaker			
☐	☐	Difficulty Breathing	☐	☐	Pneumocystitis			
☐	☐	Drug Abuse	☐	☐	Psychiatric Problems			
☐	☐	Emphysema	☐	☐	Radiation Therapy			
☐	☐	Epilepsy	☐	☐	Rheumatic Fever			
☐	☐	Fainting Spells	☐	☐	Seizures			

OFFICE USE ONLY
Medical History Update:
Date:____________________________
____
Date:____________________________
____
Date:____________________________
____
____
Date:____________________________
____

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 her staff, responsible for errors or omissions that I may have made in the completion of this form.

Signature of Patient (or responsible party)____

FOR COMPLETION BY THE DENTIST Comments on patient interview concerning medical history and/or significant findings

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DATE______________________________ **SIGNATURE OF DENTIST**________________________________