MEDICAL HISTORY

Patient Name:_____ **DOB:**_____ **Today's Date:**_____

Your health problems that you have or medication that you are taking could have an important relationship with your dental treatment. Thank you for allowing us to know you better and be appropriate with our dental care.

Are you in good health now? ❑ Yes ❑ No Are you under the care of a physician? ❑ Yes ❑ No

Your Physician's Name_____ Phone_____

Have you ever been hospitalized or had a serious illness? ❑ Yes ❑ No

Explain:_____

Do you have: Please check

☑ **NO** ☑ **PAST** ☑ **NOW**

EYES/EARS/NOSE/THROAT

❑ ❑ ❑ Glaucoma
❑ ❑ ❑ Ear aches
❑ ❑ ❑ Ear infections
❑ ❑ ❑ Loss of hearing
❑ ❑ ❑ Ringing in ears
❑ ❑ ❑ Frequent nosebleeds
❑ ❑ ❑ Sinus problems

NERVOUS SYSTEM

❑ ❑ ❑ CVA or Stroke
❑ ❑ ❑ Convulsions/Epilepsy
❑ ❑ ❑ Numbness/Tingling
❑ ❑ ❑ Dizziness/Fainting
❑ ❑ ❑ Psychiatric care

RESPIRATORY SYSTEM

❑ ❑ ❑ Hay fever
❑ ❑ ❑ Tuberculosis
❑ ❑ ❑ Asthma
❑ ❑ ❑ Difficulty breathing
❑ ❑ ❑ Emphysema

CIRCULATORY SYSTEM

❑ ❑ ❑ Rheumatic fever
❑ ❑ ❑ Heart murmur
❑ ❑ ❑ Mitral valve prolapsed
❑ ❑ ❑ Arteriosclerosis
❑ ❑ ❑ Chest discomfort/pain
❑ ❑ ❑ Heart attack/trouble
❑ ❑ ❑ Swelling of ankles
❑ ❑ ❑ Shortness of breath
❑ ❑ ❑ Congestive heart failure
❑ ❑ ❑ Artificial heart valve
❑ ❑ ❑ Pacemaker
❑ ❑ ❑ Congenital heart disease
❑ ❑ ❑ High blood pressure
❑ ❑ ❑ Other_____

ENDOCRINE

❑ ❑ ❑ Diabetes
❑ ❑ ❑ Family history of diabetes
❑ ❑ ❑ Hypoglycemia
❑ ❑ ❑ Thyroid condition
❑ ❑ ❑ Other_____

DIGESTIVE SYSTEM

❑ ❑ ❑ Hepatitis A (infectious)
❑ ❑ ❑ Hepatitis B (serum)
❑ ❑ ❑ Hepatitis C
❑ ❑ ❑ Jaundice/liver issues
❑ ❑ ❑ Ulcers/Stomach issues
❑ ❑ ❑ Special diets
❑ ❑ ❑ Cold sores

URINARY SYSTEM

❑ ❑ ❑ Kidney disease
❑ ❑ ❑ Increase in frequency

BLOOD SYSTEM

❑ ❑ ❑ Abnormal bleeding
❑ ❑ ❑ Bleeding tendency
❑ ❑ ❑ Bruise easily
❑ ❑ ❑ Anemia
❑ ❑ ❑ Blood transfusions
❑ ❑ ❑ HIV Positive/AIDS

OTHER

❑ ❑ ❑ Osteoporosis
❑ ❑ ❑ Arthritis/Rheumatism
❑ ❑ ❑ Artificial limb or joint
❑ ❑ ❑ Venereal disease
❑ ❑ ❑ Cancer
❑ ❑ ❑ Chemo/radiation therapy
❑ ❑ ❑ Are you pregnant?

DIETARY

❑ ❑ ❑ Food allergies
❑ ❑ ❑ Alcohol>2 times/week
❑ ❑ ❑ Cigarettes, Quantity_____
❑ ❑ ❑ Tobacco use
❑ ❑ ❑ Recreational drugs

SLEEP DEPRIVATION DISEASE

❑ ❑ ❑ Do you snore?
❑ ❑ ❑ Restless sleeper
❑ ❑ ❑ Chronically tired
❑ ❑ ❑ Decreased in energy
❑ ❑ ❑ Depression
❑ ❑ ❑ Gasp for air at night
❑ ❑ ❑ Sleep apnea

CRANIO-MANDIBULAR DISORDERS

❑ ❑ ❑ Tension headaches
How often?_____ Since:_____
❑ ❑ ❑ Migraine headaches
❑ ❑ ❑ Neck/Back problems
❑ ❑ ❑ Involved in car accident
❑ ❑ ❑ Clench or grind teeth
❑ ❑ ❑ Clicking jaw joints
❑ ❑ ❑ Jaws lock

ALLERGIES

❑ ❑ ❑ Latex gloves
❑ ❑ ❑ Local anesthetic (novocaine)
❑ ❑ ❑ Penicillin
❑ ❑ ❑ Erythromycin
❑ ❑ ❑ Aspirin or Codeine
❑ ❑ ❑ Sulfa drugs
❑ ❑ ❑ Metals
❑ ❑ ❑ Other_____

Are you taking any **MEDICATIONS?** ❑ NO ❑ YES If so, list medications and for what use:

Med:_____ Why?_____ Med:_____ Why?_____

Med:_____ Why?_____ Med:_____ Why?_____

Is there any other disease, condition or problem that you think we should know about? ❑ NO ❑ YES

Please explain: _____

I hereby state that this medical history form is correct to the best of my knowledge.

Signature *(Guardian's Signature if Patient is a minor)*: _____

Annual Review Date***(patient)***: _____ Initial: _____ Annual Review Date: _____ Initial: _____

Annual Review Date***(provider)***:_____ Initial: _____ Annual Review Date: _____ Initial: _____