



Date _____

Name _____ Age _____ Birth Date _____
Social Security No. _____ Family Physician _____
How did you hear about our office? _____ Have you heard our radio ads? _____
Marital Status _____ E-mail _____

MEDICAL HISTORY

A MESSAGE ABOUT HEALTH HISTORIES AND DENTISTRY

Although Dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving. We are legally obligated to ask the following questions. Your answers will be treated as strictly confidential. Thank you for answering them.

Are you presently under the care of a physician for any illness or health problem?
Have you been seen by a physician during the past year?
Have you ever had a prolonged illness or hospitalization?
How would you describe your general health? Good Fair Poor Date of last visit to your physician

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THESE ILLNESSES:

- Yes No Yes No Yes No
Anemia Asthma Diabetes
Angina Pectoris Blood Diseases Abnormal Thirst
(Chest pain or pressure) Cancer or Tumors Frequent Urination (>6x/day)
Arthritis, Sore Joints Chronic Fatigue Syndrome Do you bruise easily?
Artificial Prosthesis or Limb Chronic Sinus Infections Epilepsy or Convulsions
Artificial Heart Valve Do you bleed long when cut? Fainting Spells

HAVE YOU EVER HAD OR RECEIVED MEDICAL CARE FOR:

- Yes No Yes No Yes No
Fibromyalgia Heart Attack HIV, AIDS, ARC
Frequent Headaches (2-3x/wk) Heart Disease High Blood Pressure
Frequent Nose Bleeds Heart Murmur Immune System Disorders
Glaucoma Heart Pacemaker Kidney Disease
Gout or Rheumatism Hepatitis, Jaundice, Liver Disease

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- Yes No Yes No Yes No
Lung Problem (COPD, Emphysema, TB) Psychiatric Care (Depression/Anxiety) Sinus Problems
Major Surgery Radiation as treatment for Cancer Spitting Up Blood
Neurologic Problems Rheumatic Fever Stomach ulcers, Reflux, Colitis
Open Heart Surgery Rheumatic Heart Disease Stroke or hardening of the arteries
Paralysis (Complete or Partial) Sexually transmitted disease Thyroid Disease

HAVE YOU EVER SHOWN AN ALLERGY TO, BECOME SICK FROM, OR BEEN TOLD NOT TO TAKE:

- Yes No Yes No Yes No Yes No
Penicillin Keflex Aspirin Novocaine/dental anesthetics
Erythromycin Other Antibiotics Codeine Other medications:
Sulfa Drugs Latex Products Hydrocodone Rash/skin reaction to metal touching skin
Hydrocortisone creams/ointments Rash/skin reaction to plastic materials

ARE YOU NOW TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS? Yes No

Name of medication Condition taken for

- Yes No
Do you smoke? Packs a day: Number of years: Do you drink any alcoholic beverages? Yes No
Do you use any other tobacco products (chewing tobacco, snuff, etc)? Tobacco: Considered quitting? Yes No
Do you take any "alternative medicines" such as herbs or dietary supplements?
Are there any medicines that you are supposed to be taking that you are not taking now?
Do you take any street or recreation drugs?
Do you have any disease, condition, or problem not listed above that you think the doctor should know about?
Do you wish to talk with the doctor privately about anything?

WOMEN ONLY:

- Yes No Yes No Yes No
Are you pregnant? Do you use birth control pills or implants? Have you passed menopause?