MEDICAL HISTORY FORM

Date____
Patient Name ________________________________
Date of Birth _________________________________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? .... Yes No
   When was your last physical examination? ________________________________
2. Are you under the care of any physician? .... Yes No
   If yes, please list the name and address of physicians below:
   ____
   ____
   ____
3. Have you had any serious illness or hospitalization within the past 5 years? .... Yes No
   If yes, please specify below:
   ____
   ____
4. Are you taking a blood thinner? .... Yes No
5. Do you have any medication allergies? .... Yes No
   If yes, please list below with reaction:
   ____
   ____
   ____
6. Are you prescribed any medication for pain management? .... Yes No
7. Do you have damaged heart valves, artificial valves or a heart murmur? .... Yes No
8. Have you had a heart attack? .... Yes No
9. Do you experience chest pain on exertion? .... Yes No
10. Do you experience shortness of breath after mild exercise? .... Yes No
11. Do you have any swelling or edema? .... Yes No
12. Do you have high blood pressure? .... Yes No
13. Have you had a stroke? .... Yes No
14. Have you had seizures? .... Yes No
15. Do you experience fainting spells? .... Yes No
16. Do you have asthma? .... Yes No
17. Do you have diabetes? .... Yes No
18. Do you have liver disease, hepatitis, or jaundice? .... Yes No
19. Do you have sleep apnea? .... Yes No
20. Do you have thyroid problems? .... Yes No
21. Do you have seasonal allergies? .... Yes No
22. Do you have COPD or Emphysema? .... Yes No
23. Do you have arthritis or swollen joints? .... Yes No
24. Do you have osteoporosis? .... Yes No
25. Do you take medication for osteopenia or osteoporosis? .... Yes No
26. Do you have stomach ulcers, esophageal reflux, or hiatal hernia? .... Yes No
27. Do you have kidney disease? .... Yes No
28. Do you have low blood pressure? .... Yes No
29. Do you have anxiety or depression? .... Yes No
30. Do you have a history of cancer? .... Yes No
31. Do you have problems with your immune system? .... Yes No
32. Do you have abnormal bleeding? .... Yes No
33. Do you have any blood disorder? .... Yes No
34. Have you had any serious trouble with previous dental treatment? .... Yes No
    If yes, please specify below:
    ____
    ____

Patient Name: ____ **DOB:** ___________________ **Date:** __________________

35. Are you wearing removable dental appliances? .... Yes No
36. Do you consume alcohol? If yes, how much? .... Yes No
37. Do you use cigarettes or other tobacco products? .... Yes No
38. Do you use any drugs, including marijuana? .... Yes No

Women

39. Are you pregnant? .... Yes No
40. Are you nursing? .... Yes No
41. Are you taking any form of birth control? .... Yes No

Please list all current prescription and non-prescription medications below:

Medication Name	Medication Dose	Medication Frequency

Please list all surgery and procedure history below:

Past Surgery/ Procedures	**Date**

I certify that I have read and understand the above content. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ________________________

Signature of Patient/ Parent or Legal Guardian Date

For office Use Only:

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