**MEDICAL HISTORY FORM** **Date:** ___________________

**Name**___________________________________ **Birth Date** ______________ **Height**____(ft)____(in) **Weight**_________(lbs)

**Spouses Name (Parent for children)**_____________________________**Who Referred You To Our Practice?**______________

**Family Physician**____________________________ **Physician Phone #**_________________**Family Dentist**_________________

**Dental Insurance Carrier and Group #**_________________________________________________________________________

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**Please circle any of the following that you have had or have now:**

| | | | |
|---|---|---|---|
| Hospitalized | High Blood pressure | Chronic cough | HIV positive |
| Operations | Frequent severe headache | Coughed up blood | AIDS |
| Cancer | Frequent nasal congestion | Tuberculosis | Cold sores |
| Tumor | Heart disease or condition | Lived with someone who had TB | Genital Herpes |
| Radiation therapy | Angina Pectoris | Asthma | Detached retina |
| Chemotherapy | Frequent chest pains | Stomach trouble | Frequent thirst |
| Blood transfusion | Artificial heart valve | Jaundice( other than at birth) | Menopause |
| Bruise easily | Heart murmur | Frequent diarrhea | Hysterectomy |
| Hemophilia | Shortness of breath | Stomach/intestinal ulcers | Diabetes |
| Von Willenbrand's disease | Congenital heart disease | Food you cannot eat | Thyroid problems |
| Prolonged unusual bleeding | Swollen ankles | Gained or lost weight recently | Drug addictions |
| Anemia | Heart attack | Kidney or bladder trouble | Implant prosthesis |
| Stroke | Skipped heart beat | Epilepsy or Seizures | Psychiatric treatment |
| Fainting/Dizzy Spells | Hepatitis | Venereal disease | Arthritis |
| Skin disease/condition | Slow healing of cuts | More than one bone fracture | Rheumatoid problems |
| Emphysema | Psychological problems | Bronchitis | Alcohol/drug abuse |
| Mitral Valve Prolapse | Osteoporosis | Osteopenia | Glaucoma |
| Congrstive Heart Disease/ Failure | | | |

(Circle the correct answer below)…………………………..…. Yes No

1. Are you in good health…………………………………………………………………………………………… Yes No
2. Has there been a major change in your health over the past year……………………………………………..……………… Yes No
3. Are you under the care of a physician for a health problem currently? … ………………………………………….……Yes No
   If yes, what is the condition? ……………………………………………………………………………..……. Yes No
4. Have you been seriously ill or hostpitalized during the past 5 years? ………………………………………………… Yes No
   If yes, for what condition?_____________________________________________________________________
5. Are you taking any prescription medicines? If yes, please name them here________________________________ . Yes No
   _________________________________________________________________________________
   _________________________________________________________________________________
6. Are you taking any non-prescription medicines? Please name them here___________________________________ . Yes No
7. Are you allergic to any medications or materials? if yes please name them here____________________________ ..Yes No
   _________________________________________________________________________________
8. Have you ever experienced complications following dental treatment? …………………………………………… …..Yes No
9. Women, are you pregnant or possibly pregnant? …………………………………………………………….……………….. ..Yes No
10. Have you ever taken or are you taking or being treated with any of the following drugs
    by pill or injection: Allendonate (Fossamax), Risendronate (Actonel), Ibandronate (Boniva) … ....................Yes No
11. Are there any conditions which you have that are not mentioned above? If yes please name here______________ ..Yes No
    _________________________________________________________________________________
12. Could you climb a full flight of stairs without stopping or getting severely out of breath? ……………………… ..Yes No
13. Do you smoke or use other tobacco products? ……………………………………………………………………… ..Yes No
14. Are you severely anxious such that you think you need sedation for some or any dental appointments? . …..............Yes No

**PATIENT SIGNATURE**________________________________________ **DATE**____________

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**COMMENTS BY DENTIST** - (PLEASE DO NOT WRITE IN THIS SPACE) **Allergies** **Medications**

**OPER CX:**

**Dentist's Signature:**