

Medical History

Patient's Name: \_\_\_\_\_

Please indicate any condition that you have now or have had in the past by checking yes or no and fill in plank space when indicated.

Are you currently under the care of a physician? Yes \_\_\_ No \_\_\_ Physician's name: \_\_\_\_\_ Physicians Phone: \_\_\_\_\_

CARDIOVASCULAR

- Heart failure Yes\_\_ No\_\_
Heart disease or attack Yes\_\_ No\_\_
Angina pectoris or chest pains Yes\_\_ No\_\_
High blood pressure Yes\_\_ No\_\_
Heart Murmur or Click Yes\_\_ No\_\_
Mitral valve prolapse Yes\_\_ No\_\_
Rheumatic fever Yes\_\_ No\_\_
Congenital heart defect or lesion Yes\_\_ No\_\_
Heart surgery or transplant Yes\_\_ No\_\_
Artificial heart valve Yes\_\_ No\_\_
Irregular heartbeat (arrhythmia) Yes\_\_ No\_\_
Heart pacemaker or defibrillator Yes\_\_ No\_\_
Other heart problem Yes\_\_ No\_\_

GASTROINTESTINAL

- Stomach or intestinal ulcers Yes\_\_ No\_\_
Gastritis Yes\_\_ No\_\_
Colitis Yes\_\_ No\_\_
Persistent diarrhea Yes\_\_ No\_\_
Hepatitis or yellow jaundice Yes\_\_ No\_\_
Cirrhosis Yes\_\_ No\_\_
Other liver problems Yes\_\_ No\_\_
Gastro-esophageal reflux Yes\_\_ No\_\_
Hiatal Hernia Yes\_\_ No\_\_

RESPIRATORY

- Hay fever Yes\_\_ No\_\_
Sinus trouble Yes\_\_ No\_\_
Asthma Yes\_\_ No\_\_
Persistent cough Yes\_\_ No\_\_
Bronchitis Yes\_\_ No\_\_
Emphysema Yes\_\_ No\_\_
Tuberculosis (TB) Yes\_\_ No\_\_
Breathing difficulties Yes\_\_ No\_\_

HEMATOLOGIC

- Blood transfusion Yes\_\_ No\_\_
Anemia Yes\_\_ No\_\_
Sickle cell (anemia) disease Yes\_\_ No\_\_
Tendency to bleed longer than normal Yes\_\_ No\_\_
Hemophillia Yes\_\_ No\_\_
Leukemia Yes\_\_ No\_\_

GENITO-URINARY

- Urinate more than 6 time per day Yes\_\_ No\_\_
Kidney or bladder problems Yes\_\_ No\_\_
Dialysis Yes\_\_ No\_\_
Sexually transmitted disease (syphilis, gonorrhea, Chlamydia, herpes) Yes\_\_ No\_\_

NEURAL

- Stroke or transient ischemia attack Yes\_\_ No\_\_
Vision problems Yes\_\_ No\_\_
Glaucoma or cataract Yes\_\_ No\_\_
Earaches, ringing in ears Yes\_\_ No\_\_
Hearing loss Yes\_\_ No\_\_
Severe headaches, migraines Yes\_\_ No\_\_
Fainting or dizzy spells Yes\_\_ No\_\_
Epilepsy, seizures, or convulsions Yes\_\_ No\_\_
Nervousness Yes\_\_ No\_\_
Psychiatric treatment Yes\_\_ No\_\_
Nerve damage Yes\_\_ No\_\_

OTHER CONDITIONS

- Enlarged lymph node or "gland" Yes\_\_ No\_\_
Persistent or unexplained fevers Yes\_\_ No\_\_
HIV positive/AIDS Yes\_\_ No\_\_
Use tobacco Yes\_\_ No\_\_
Use alcohol Yes\_\_ No\_\_
Drug addiction Yes\_\_ No\_\_
Tumor or cancer Yes\_\_ No\_\_
Radiation treatment Yes\_\_ No\_\_
Chemo-therapy Yes\_\_ No\_\_

ENDOCRINE

- Diabetes Yes\_\_ No\_\_
Thyroid disease Yes\_\_ No\_\_

ALLERGIES

- Are you allergic to:
Local anesthetics (novocaine) Yes\_\_ No\_\_
Penicillin or other antibiotics Yes\_\_ No\_\_
Aspirin Yes\_\_ No\_\_
Codeine or other pain medications Yes\_\_ No\_\_
any other drug or medicine (list below) Yes\_\_ No\_\_

DERMAL/ORAL/MUSCULOSKELETAL

- Allergy to latex (rubber) Yes\_\_ No\_\_
Skin rash or hives Yes\_\_ No\_\_
Arthritis, rheumatism or gout Yes\_\_ No\_\_
Artificial joint Yes\_\_ No\_\_
Fever Blisters Yes\_\_ No\_\_
Mouth ulcers or canker sores Yes\_\_ No\_\_

Are you taking (or suppose to be taking) any medicine, drugs, or pills of any kind? Yes\_\_\_ No\_\_\_

If yes , what kind and dose?

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Have you ever been hospitalized and/or had operation or surgery?  
Describe when and why:

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Are you allergic to any foods, clothing, animals, etc?	Yes ___ No ___
Have you taken cortisone, prednisone or other steroids in the past 12 months	Yes ___ No ___
When you walk up stairs or take a walk, do you have to stop because of pain in your chest Shortness of breath or feeling tired?	Yes ___ No ___
Do your ankles swell during the day?	Yes ___ No ___
Do you sleep on two or more pillows?	Yes ___ No ___
Have you <b>unintentionally</b> lost or gained more than 10 pounds in the past year?	Yes ___ No ___
Are you on a special diet?	Yes ___ No ___
Has your occupation ever brought you in contact with blood, blood products, or needles?	Yes ___ No ___

#### DENTAL HISTORY

Do you make regular (non-emergency) visits to the dentist?	Yes ___ No ___
Do your teeth feel loose?	Yes ___ No ___
Do your gums bleed when you brush your teeth?	Yes ___ No ___
Are any of your teeth painful to biting or chewing?	Yes ___ No ___
Do you ever have pain, or experience clicking, popping or grinding when you open and close your mouth?	Yes ___ No ___
Do you grind or frequently clench your teeth?	Yes ___ No ___
Does your mouth frequently feel dry?	Yes ___ No ___
Have you ever worn braces or false teeth?	Yes ___ No ___
Do you gag easily or do you have a problem with gagging during dental treatment?	Yes ___ No ___
Have you ever fainted or had a bad experience related to dental treatment?	Yes ___ No ___

#### WOMEN ONLY:

Is there a possibility you may be pregnant?	Yes ___ No ___
Are you nursing?	Yes ___ No ___
Are you taking birth control pills?	Yes ___ No ___
Do you have any other disease, condition, or problem not listed on this form? If yes , then please explain below:	Yes ___ No ___

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In order to best treat your dental health needs, please explain why you came in today.

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To the best of my knowledge, the stated responses are correct and true. If there are any changes in my health history, I will inform the dentist at the next appointment.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date