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# Medical History Form

**NAME:**

	Yes	No	Unknown
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has there been any change in your general health within the past year? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you under the care of a physician for a current problem? If yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been hospitalized within the past 5 years? If yes, please specify.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is there any condition concerning your health that the doctor should be told?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you wish to speak to the doctor privately about anything?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had abnormal bleeding with previous extractions, surgeries, or trauma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever required a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever tested positively for HIV infection or AIDS? If so, date diagnosed and the treating doctor:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you required to take antibiotics prior to dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Have you had any of the following? If yes, please check box below.

High blood pressure	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>
Heart murmur or prolapsed valve	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>
Joint prosthesis (hip, knee, etc.)	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Rheumatic fever/rheumatic heart disease	<input type="checkbox"/>	Stomach ulcers, colitis	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	Hepatitis, jaundice, liver disease	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>
Prosthetic heart valve	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>
Blood disorder (e.g., anemia)	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>
Venereal disease	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Allergy to latex	<input type="checkbox"/>	Temporomandibular joint problems (TMJ)	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	Low blood sugar	<input type="checkbox"/>
Chest pain, angina	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>
Swollen ankles, arthritis or joint disease	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>
Cardiac pacemaker	<input type="checkbox"/>	Contagious diseases	<input type="checkbox"/>
Heart surgery	<input type="checkbox"/>	Bronchitis, chronic cough	<input type="checkbox"/>
Delay in healing	<input type="checkbox"/>	Hay fever or sinus problems	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Problems with the immune system	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Difficult breathing or other lung trouble	<input type="checkbox"/>
X-ray treatment or chemotherapy	<input type="checkbox"/>	Chronic fatigue or night sweats	<input type="checkbox"/>
On a diet	<input type="checkbox"/>	History of drug abuse	<input type="checkbox"/>
History of alcohol abuse	<input type="checkbox"/>	Wear contact lenses	<input type="checkbox"/>
Eye disease or glaucoma	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>
Infectious mononucleosis	<input type="checkbox"/>	Gallbladder trouble	<input type="checkbox"/>

	Yes	No	Unknown
15. Are you taking any herbal medicine (i.e., St. Johns Wort)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever taken the "fen-phen" diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have any disease, condition, or problem not listed above? Specify.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you taking any medications or drugs? If yes, please list them on the <b>next page</b> :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you taking bisphosphonates now or have you in the past? (Fosamax)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please continue on other side.**

**Please list your medications below:**

**Women only:**

Possibility of pregnancy:	YES / NO	Nursing:	YES / NO
Estimated delivery date:		Taking birth control pills:	YES / NO

**NOTE:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

**If This visit is related to an injury, fill out the fields below:**

<input type="checkbox"/> Accident related	<input type="checkbox"/> Work related
Date of Injury:	
Insurance Company Handling Claim:	
Claim Number:	
Name of Attorney / Adjustor:	
Attorney / Adjustor Telephone #:	

**Physician's Info:**

**Emergency Contact Info:**

Physician Name:	Name:
Physician Phone:	Work Phone:
Specialist Name:	Home Phone:
Specialist Phone:	

\_\_\_\_\_  
**Patient Signature** (Parent signature if patient is under 18 years of age)

\_\_\_\_\_  
**Date**