

MEDICAL HEALTH HISTORY

Name of Physician _____ Physician's phone # _____
 Name of previous dentist _____ Reason for leaving _____
 Date of last visit to physician _____

Do you have or have you had, any of the following? Please answer Yes or No or explain.

Heart Problems

	YES	NO
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Blood Problems

Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia)	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Allergy Problems

Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Intestinal Problems

Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>
Special diet	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Bone or Joint Problems

Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement (e.g., total hip)	<input type="checkbox"/>	<input type="checkbox"/>
Pins or metal rods	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Fainting Spells, Seizures, or Epilepsy

	YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Jaundice, or Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
HIV-Positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>

Have you been hospitalized during the past 5 years?

	<input type="checkbox"/>	<input type="checkbox"/>
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Do you have any disease, problem or condition not listed?

Do you have any psychiatric problems?

During the last 12 months have you taken any of the following?

Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizer	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin (Daily)	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerine	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
List meds you take every day	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

REMARK DOCTOR USE

Are you allergic or have you reacted adversely to any of the following:

Local anesthetics (Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Woman

	YES	NO
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

REVIEWED MEDICAL HISTORY

DOCTOR INITIAL

DATE