MEDICAL HISTORY

Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
Height: _____ Weight: _____ Cell or Work Phone: _____
Physician_____ Office Phone_____ Date of last exam_____

Answer all questions by circling Yes (Y) or No (N).

1. Are you in general good health at this time? ....Y N
2. Are you under any medical treatment now? ....Y N
3. Have you had any serious illnesses, operations or hospitalizations? …….....Y N
   If yes please list.

_____
_____

4. **Do you have or have you ever had:**
   - A. A Heart Ailment? .....……Y N
   - B. High Blood Pressure?.....Y N
   - C. Respiratory Disease?. .....Y N
   - D. Diabetes? ……..Y N
   - E. Rheumatic Fever? ……Y N
   - F. Rheumatism or Arthritis? …….……Y N
   - G. Tumors or Growths? ..... Y N
   - H. Blood Disease? ….…….……....Y N
   - I. Liver Disease, Jaundice or Hepatitis?..... Y N
   - J. Kidney Disease? ……..……...Y N
   - K. Stomach or Intestinal Disease? …… Y N
   - L. Venereal Disease? …….Y N
   - M. HIV+/AIDS? ……Y N
   - N. Epilepsy? ……...Y N
   - O. Implants placed anywhere in your body? ..Y N
   - P. Psychiatric or Emotional Disorder? ……. Y N
   - Q. Alcohol or Chemical Dependency?.....Y N
   - R. Head Injuries? ……....Y N

5. **Are you now using any of the following**:
   - A. Antibiotics?...……..Y N
   - B. Anticoagulants (Blood Thinners)?..……Y N
   - C. Aspirin, Motrin, Aleve, Ibuprofen?.....Y N
   - D. Blood Pressure Medication?.....Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? Y N
   - F. Tranquilizers?.....Y N
   - G. Insulin or Oral Anti-Diabetic drugs?.....Y N
   - H. Digitalis, Inderal Nitroglycerin or other heart drug?.....Y N
   - I. Other medications not listed above, including prescription, over-the-counter, diet, herbal, vitamins? (please list):

_____
_____
_____
_____

6. **Have you ever taken**:

All responses are kept confidential.

- A. Pre-med before dental treatment?..... Y N
- B. Fosomax, Actonel, Didronel or Skelid for Osteoporosis?..... Y N
- C. Fen-Phen? ……Y N
- D. Chemotherapy or Radiation? ……..…… Y N

7. **Have you had any adverse or allergic reactions to**:
   - A. Penicillin or other antibiotics?..... .....Y N
   - B. Sedatives or Barbiturates?.....Y N
   - C. Aspirin or Ibuprofen? ……Y N
   - D. Codeine or other pain killers? ……Y N
   - E. Metals or Jewelry?.....Y N
   - F. Chemicals? ……. Y N

B. Metals or Jewelry.....Y N
   - G. Latex or Rubber Products ……..…Y N
   - H. Food Products? ……...Y N
   - I. Local Anesthesia (Novacain, etc.)?..……...Y N
   - J. Other allergies or reactions? Please list:

_____
_____

8. Are you on a diet at this time? .....Y N

9. Have any wounds healed slowly or presented other complications? .....Y N

10. Are you pregnant or nursing? .....Y N

11. Do you have a history of fainting? .....Y N

12. Do you smoke or chew Tobacco? ……..Y N
    If yes, how much per day? _____

DENTAL HISTORY

13. **Do you or have you had**:
   - A. Pain in or near your ears? .....Y N
   - B. Injuries or inflamed areas in your mouth? ..Y N
   - C. Any growths or sore spots in your mouth?..Y N
   - D. Pain in your mouth when clenched? ……..Y N
   - E. Any difficult extractions in the past? .....Y N
   - F. Prolonged bleeding after an extractions?....Y N
   - G. Bleeding Gums? .....Y N
   - H. Chew on only one side of your mouth?.....Y N
   - I. Habitually clench your teeth? .....Y N
   - J. Sensitivity to pressures or irritants (cold, sweets)? ……...Y N
   - K. Any dental complaints? .....Y N

14. When was your last full mouth X-RAY taken?
    _____Where?_____

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Signature: _____ **Date**: _____

OFFICE USE ONLY

Updated_____ Initials_____ Updated_____ Initials_____
Updated_____ Initials_____ Updated_____ Initials_____