

**Medical History Form**

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

For the following questions, circle yes or no, whichever applies. Your answers are for our record only and will be considered confidential.

- 1. Are you in good health? \_\_\_\_\_ Yes No
- 2. Has there been any change in your general health within the past year? \_\_\_\_\_ Yes No
- 3. My last physical examination was on: \_\_\_\_\_
- 4. Are you now under the care of a physician? \_\_\_\_\_ Yes No  
If yes, what condition is being treated? \_\_\_\_\_
- 5. The name and address of my physician is: \_\_\_\_\_
- 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? \_\_\_\_\_ Yes No  
If so, what was the illness or problem? \_\_\_\_\_
- 7. Are you taking any **medication**, including non-prescription and supplements? \_\_\_\_\_ Yes No  
If so, what medicines, supplements or non-prescription medicines are you taking? **Please list all medications below:**

- 8. Do you have or have you had any of the following diseases or problems?
  - Damaged heart valves or artificial heart valves, including heart murmur or rheumatic disease \_\_\_\_\_ Yes No
  - Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure, stroke, atherosclerosis) \_\_\_\_\_ Yes No
  - Do you have a cardiac pacemaker? \_\_\_\_\_ Yes No
  - Allergy or sinus trouble \_\_\_\_\_ Yes No
  - Respiratory problems (asthma, emphysema, bronchitis) \_\_\_\_\_ Yes No
  - Fainting spells or seizures \_\_\_\_\_ Yes No
  - Diabetes \_\_\_\_\_ Yes No
  - Hepatitis (which type?) or liver problems \_\_\_\_\_ Yes No
  - Aids or HIV infection \_\_\_\_\_ Yes No
  - Thyroid problems \_\_\_\_\_ Yes No
  - Arthritis (osteoarthritis or Rheumatoid) \_\_\_\_\_ Yes No
  - Stomach ulcer or hyperacidity \_\_\_\_\_ Yes No
  - Kidney trouble \_\_\_\_\_ Yes No
  - Tuberculosis \_\_\_\_\_ Yes No
  - High/Low blood pressure \_\_\_\_\_ Yes No
  - Epilepsy or neurological disease \_\_\_\_\_ Yes No
  - Problems with mental health/depression \_\_\_\_\_ Yes No
  - Eating Disorder \_\_\_\_\_ Yes No

- 9. Are you **allergic** or have you had any reactions to:
 

Local anesthetics	Penicillin or other antibiotics	Sulfa drugs	Aspirin
Codeine or other narcotics	Barbiturates, sedatives or sleeping pills	Iodine	Other _____

10. Do you have any other disease or conditions not listed that you feel we should know about? If so, please explain.

\_\_\_\_\_

- 11. Do you **smoke** or use tobacco of any type? \_\_\_\_\_ Yes No  
If so, which type? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

**WOMEN:** Are you pregnant or is there a possibility you could be pregnant? Yes No  
Do you take birth control pills? Yes No Are you nursing? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her/his staff, responsible for any errors or omissions that I may have made in the completion of this form.

**Signature of Patient:** \_\_\_\_\_

For Dentist/Hygienist: comments concerning medical history \_\_\_\_\_

Dental management considerations \_\_\_\_\_

Signature of Dentist/Hygienist \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_