

# MEDICAL HISTORY

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Marital Status \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Birth date \_\_\_\_\_ S. S. No. \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ Bus Phone \_\_\_\_\_  
In Case Of Emergency (Closest Relative or Friend) Name \_\_\_\_\_ Phone \_\_\_\_\_  
Previous Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_ Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_  
**Referred By** \_\_\_\_\_ Email \_\_\_\_\_

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

1. Are you in good health?.....YES NO
2. Do you require premedication prior to dental treatment?.....YES NO
  - a. If yes, which antibiotic? \_\_\_\_\_
3. My last physical examination was on \_\_\_\_\_
4. Are you now under the care of a physician?..... YES NO
  - a. If so, what is the condition being treated? \_\_\_\_\_
5. The name and address of my physician is \_\_\_\_\_

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6. Have you had any serious illness or operation?.....YES NO
  - a. If so, what was the illness or operation? \_\_\_\_\_
7. Have you been hospitalized or had a serious illness within the past five (5) years? .....YES NO
  - a. If so, what was the problem? \_\_\_\_\_
8. Do you have or have you had any of the following diseases or problems?
  - a. Damaged heart valves, artificial heart valves, artificial veins or arteries.....YES NO
  - b. Congenital heart lesions.....YES NO
  - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke).....YES NO
    - 1) Do you have pain in the chest upon exertion?.....YES NO
    - 2) Are you ever short of breath after mild exercise?.....YES NO
    - 3) Do your ankles swell?.....YES NO
    - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?.....YES NO
    - 5) Do you have a cardiac pacemaker?.....YES NO
  - d. Diabetes.....YES NO
    - 1) Do you have to urinate (pass water) more than six times a day?.....YES NO
    - 2) Are you thirsty much of the time?.....YES NO
    - 3) Does your mouth frequently become dry?.....YES NO
  - e. Allergy: Chemical or Food (Circle One).....YES NO
  - f. Asthma or hay fever (Circle One) .....YES NO
  - g. Hives or a skin rash (Circle One) .....YES NO
  - h. Fainting spells or seizures (Circle One) .....YES NO
  - i. Severe or Frequent Headaches (Circle One) .....YES NO
  - j. Sinus trouble or Seasonal Allergies (Circle One).....YES NO
  - k. Hepatitis, jaundice or liver disease (Circle One) .....YES NO
  - l. Arthritis.....YES NO
  - m. Inflammatory rheumatism (painful swollen joints).....YES NO
  - n. Stomach ulcers.....YES NO
  - o. Kidney trouble.....YES NO
  - p. Tuberculosis.....YES NO
  - q. Do you have a persistent cough or cough up blood?.....YES NO
  - r. Low blood pressure.....YES NO
  - s. Fever Blisters.....YES NO
  - t. Blood Transfusion .....YES NO
  - u. Drug and/or alcohol abuse.....YES NO
  - v. Psychiatric Problems .....YES NO
  - w. Venereal Disease or Herpes (Circle One) .....YES NO
  - x. Tested HIV positive.....YES NO

OVER

9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?.....YES NO  
a. Do you bruise easily? .....YES NO  
b. Have you ever required a blood transfusion?.....YES NO  
When? \_\_\_\_\_ If so, explain, the circumstances. \_\_\_\_\_

10. Do you have any blood disorders such as anemia?.....YES NO

11. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck?.....YES NO

12. Are you taking any drug or medicine?.....YES NO  
If so, what? \_\_\_\_\_

13. Are you taking any of the following: (Please List)

- a. Antibiotics or Sulfa drugs.....YES NO
- b. Anticoagulants (blood thinners) .....YES NO
- c. Medicine for high blood pressure.....YES NO
- d. Cortisone (steroids).....YES NO
- e. Tranquilizers.....YES NO
- f. Antihistamines.....YES NO
- g. Aspirin.....YES NO
- h. Insulin, tolbutamide (Orinase) or similar drug.....YES NO
- i. Digitalis or drugs for heart trouble.....YES NO
- j. Nitroglycerine.....YES NO
- k. Oral contraceptive or other hormone therapy (Circle One) ..... YES NO
- l. Other: \_\_\_\_\_ YES NO

14. Are you allergic to have you reacted adversely to:

- a. Local anesthetics.....YES NO
- b. Penicillin or other antibiotics.....YES NO
- c. Sulfa drugs.....YES NO
- d. Latex.....YES NO
- e. Barbiturates, sedatives, or sleeping pills.....YES NO
- f. Iodine.....YES NO
- g. Aspirin.....YES NO
- h. Codeine or other narcotics.....YES NO
- i. Other \_\_\_\_\_ YES NO

15. Have you had any serious trouble associated with any previous dental treatment?.....YES NO  
If so, explain \_\_\_\_\_

16. Do you have any disease, condition, or problem not listed above that you think that I should know about?.....YES NO  
If so, explain \_\_\_\_\_

17. Are you employed in any situation which exposes you regularly to X-ray or other ionizing radiation?.....YES NO

18. Are you wearing contact lenses?.....YES NO

19. Do you have any artificial joints?.....YES NO

WOMEN:

20. Are you pregnant?.....YES NO

21. Are you nursing?.....YES NO

CHIEF DENTAL COMPLAINT: \_\_\_\_\_

22. Do you like your smile? .....YES NO

23. Do your gums ever bleed? .....YES NO

24. Do you floss? Y N How often? \_\_\_\_\_ Type of tooth bristles: \_\_\_ Hard \_\_\_ Soft \_\_\_ Medium

25. Do you use tobacco products? \_\_\_\_\_ What type? \_\_\_\_\_

### Consent for Treatment

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic and I will assume responsibility for all fees associated with those procedures. I will be responsible for ALL balances over 60 days and understand these balances will be subject to a 18% Finance Charge. Please give a 24 hour notice on cancellations or you will be subject to a fee.

(Patient's Parent's) Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_