

MEDICAL HISTORY FORM UPDATE

Name: Mr. Mrs. Miss Ms.	Dr.	Social Security Number	Date
Residence Address (include ZIP code)			Residence Telephone
Firm Employed by	Position		Date of Birth
Business Address			Business Telephone
Email Address			Cell Phone Number
Emergency Contact Person		Emergency Phone Number	

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

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 under the care of a physician?..... Yes No
If so, what is the condition being treated? _____
5. The name and address of my physician(s) 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 medicine(s) including non-prescription medicine?..... Yes No
If so, what medicine(s) are you taking? _____
8. Do you have or had any of the following diseases or problems?
 - a. Damaged or artificial heart valves, heart murmur or rheumatic heart disease..... Yes No
 - b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
 1. Do you have chest pain upon exertion?..... Yes No
 2. Are you short of breath after exercise or when lying down?..... Yes No
 3. Do your ankles swell?..... Yes No
 4. Do you have any inborn heart defects (mitral valve prolapse)?..... Yes No
 5. Do you have a cardiac pacemaker?..... Yes No
 - c. Allergy..... Yes No
 - d. Sinus trouble..... Yes No
 - e. Asthma or hay fever..... Yes No
 - f. Fainting spells or seizures..... Yes No
 - g. Persistent diarrhea or recent weight loss..... Yes No
 - h. Diabetes..... Yes No
 - i. Hepatitis, jaundice or liver disease..... Yes No
 - j. AIDS or HIV infection..... Yes No
 - k. Thyroid problems..... Yes No
 - l. Respiratory problems, emphysema, bronchitis, etc..... Yes No

(over)

- | | | | |
|------------|--|-----|----|
| m. | Arthritis or painful swollen joints..... | Yes | No |
| n. | Stomach ulcer or hyperacidity..... | Yes | No |
| o. | Kidney trouble..... | Yes | No |
| p. | Tuberculosis..... | Yes | No |
| q. | Persistent cough or cough that produces blood..... | Yes | No |
| r. | Persistent swollen glands in neck..... | Yes | No |
| s. | Low blood pressure..... | Yes | No |
| t. | Sexually transmitted disease..... | Yes | No |
| u. | Epilepsy or other neurological disease..... | Yes | No |
| v. | Problems with mental health..... | Yes | No |
| w. | Cancer..... | Yes | No |
| x. | Problems of the immune system..... | Yes | No |
| z. | Orthopedic replacements (hip, knee, etc.)..... | Yes | No |
| 9. | Have you had abnormal bleeding?..... | Yes | No |
| a. | Have you ever required a blood transfusion?..... | Yes | No |
| 10. | Do you have any blood disorder such as anemia?..... | Yes | No |
| 11. | Have you ever had any treatment for a tumor or growth?..... | Yes | No |
| 12. | Are you allergic to or have you had a reaction to: | | |
| a. | Local anesthetics..... | Yes | No |
| b. | Penicillin or other antibiotics..... | Yes | No |
| c. | Sulfa drugs..... | Yes | No |
| d. | Barbiturates, sedatives or sleeping pills..... | Yes | No |
| e. | Aspirin..... | Yes | No |
| f. | Iodine..... | Yes | No |
| g. | Codeine or other narcotics..... | Yes | No |
| h. | Other..... | Yes | No |
| 13. | Have you had any serious trouble associated with any previous dental treatment?..... | Yes | No |
| | If so, explain _____ | | |
| 14. | Do you have any disease, condition or problem not listed that we should know about?..... | Yes | No |
| | If so, explain _____ | | |
| 15. | Are you wearing contact lenses?..... | Yes | No |
| 16. | Are you wearing removable dental appliances?..... | Yes | No |

Women

- | | | | |
|------------|--|-----|----|
| 17. | Are you pregnant?..... | Yes | No |
| 18. | Do you have any problems associated with your menstrual period?..... | Yes | No |
| 19. | Are you nursing?..... | Yes | No |
| 20. | Are you taking birth control pills?..... | Yes | No |

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

Signature of Patient

Date

Signature of Dentist