NEW PATIENT MEDICAL HISTORY FORM

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
Emergency Contact Person and Phone Number		Cell Phone Number
E-mail Address	Referred by	
Last Visit to a Dentist	Purpose of Visit	

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 have you 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

	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? If so, explain ________		Yes	No
14.	Do you have any disease, condition or problem not listed that we should know about? If so, explain ________		Yes	No
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

Chief Dental Complaint________________________

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