

**Patient name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICAL HISTORY**

Name of person completing this section (if different than patient) and relationship to patient: \_\_\_\_\_

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

**PLEASE ANSWER BY CIRCLING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION:**

- 1. Are you in good health? ..... Y N
- 2. Has there been any change in your general health in the past year? ..... Y N
- 3. Date of last check up by physician: \_\_\_\_\_
- 4. Are you currently under a physician's care? ..... Y N  
If so, what for? \_\_\_\_\_

Treating physician's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

- 5. Have you had any serious illness, operations, or hospitalization?  
If so, describe and give approximate dates: \_\_\_\_\_  
\_\_\_\_\_

- 6. Have you ever had intravenous sedation or general anesthesia? ..... Y N  
Were there any adverse effects? ..... Y N

- 7. Do you generally tolerate dental treatment well? ..... Y N

- 8. DO YOU HAVE OR HAVE YOU EVER HAD:
  - A. Heart disease that was detected at birth? ..... Y N
  - B. Rheumatic fever or Rheumatic heart disease? ..... Y N
  - C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? ..... Y N
  - D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? ..... Y N
  - E. Neurologic disorders (seizures, epilepsy, fainting, dizziness, nervous disorder)? ..... Y N
  - F. Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? ..... Y N
  - G. Liver disease (jaundice, hepatitis)? ..... Y N
  - H. Kidney disease? ..... Y N
  - I. Diabetes? ..... Y N
  - J. Thyroid disease? ..... Y N
  - K. Arthritis? (which joints?) ..... Y N
  - L. Stomach ulcers or intestinal problems? ..... Y N
  - M. Glaucoma? ..... Y N
  - N. Frequent or recurring mouth sores? ..... Y N
  - O. Implants/artificial joints anywhere in the body? (heart valve, hip, knee)? ..... Y N
  - P. Radiation therapy (X-ray treatment for cancer) in head or neck region? ..... Y N
  - Q. Noises in jaw joint, pain near ear when chewing, or do you grind or clench your teeth? ..... Y N
  - R. Sinus or nasal problems? ..... Y N
  - S. Any disease, drug, or transplant operation that has depressed your immune system? ..... Y N
  - T. Recurrent infections of any kind? ..... Y N

- 9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING:
  - A. Antibiotics? ..... Y N
  - B. Anticoagulants (blood thinners or aspirin)? ..... Y N
  - C. Thyroid medications? ..... Y N
  - D. Antihistamines, decongestants? ..... Y N
  - E. High blood pressure or heart medication? ..... Y N
  - F. Steroids? ..... Y N
  - G. Tranquilizers, antidepressants? ..... Y N
  - H. Stomach or GI medications (antacids, etc.)? ..... Y N
  - I. Cholesterol reducing drugs? ..... Y N
  - J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain reliever? ..... Y N
  - K. Weight reduction pills or diet aids (OTC or "natural" products)? ..... Y N
  - L. Vitamins, Natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements? ..... Y N
  - M. Marijuana, cocaine, or other "recreational" drugs? ..... Y N

N. Any other regular medications, pills, supplements, or drugs? ..... Y N  
**PLEASE LIST ALL CURRENT MEDICATIONS/DRUGS/SUPPLEMENTS ("YES" ON 9A - 9N) HERE:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:
- A. Local anesthetic (Novocaine-like drug)? ..... Y N
  - B. Penicillin, Amoxicillin, Cephalosporins? ..... Y N
  - C. Other antibiotics? ..... Y N
  - D. Barbiturates, sedatives? ..... Y N
  - E. Aspirin, ibuprofen, NSAIDS, or other pain medicines? ..... Y N
  - F. Codeine or other narcotics or opioids? ..... Y N
  - G. Latex? ..... Y N
  - H. Other allergies or reactions? ..... Y N
- Please list: \_\_\_\_\_

11. Do you have hay fever, frequent skin rashes, etc.? ..... Y N
12. Do you use alcohol? How much per day? \_\_\_\_\_ Y N
13. Do you smoke? ..... Y N  
What product and how many per day? \_\_\_\_\_ For how long? \_\_\_\_\_
14. Do you use spit tobacco? ..... For how long? \_\_\_\_\_ Y N
15. Are you, or have you ever been, in a drug or alcohol recovery program? ..... Y N
16. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? Y N
17. Do you wish to talk to the doctor privately about anything? ..... Y N
18. Any additional comments? \_\_\_\_\_

19. **WOMEN ONLY**
- A. Are you taking birth control medication? ..... Y N
  - B. Are you pregnant, trying to become pregnant, or any chance you might be pregnant? ..... Y N
  - C. Are you breast feeding? ..... Y N
  - D. Are you taking hormonal replacement? ..... Y N

**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.**

\_\_\_\_\_  
Date Signature of person completing health history Doctor's Initials

**THANK YOU! Please do not write below this line.**

Medical Update: I have reviewed my prior health history dated \_\_\_\_\_ and confirm it accurately states past and present conditions with NO \_\_\_\_\_/FOLLOWING \_\_\_\_\_ exceptions: \_\_\_\_\_

\_\_\_\_\_  
Date Signature of person completing health history Doctor's initials