

MEDICAL HISTORY

Patient Name _____ Date _____

Because dentistry frequently requires the use of drugs or invasive procedures, it is important that we have certain information about your health. All information on this form is strictly **CONFIDENTIAL**, and cannot be released to any other person or agency without your written permission. Please answer all of the following questions:

1. What is your estimate of your general health? (circle) POOR FAIR GOOD EXCELLENT

2. Have you been hospitalized during the past two years? YES NO

Reason? _____

3. Are currently under the care of a physician? YES NO

Reason? _____

4. Physician & hospital's name _____

5. Do you need to be Pre-Medicated for your Dental Appointments? YES NO

6. Do you have or have you had any of the following:

Cardiovascular Disorders:

Yes No

- High blood pressure
- Congenital Heart Disease
- Rheumatic Fever
- Heart Murmur
- Heart Pacemaker
- Vascular graft
- Heart or bypass surgery
- Artificial Heart Valve
- Heart Attack
- Congestive Heart Failure
- Awaken with breathing difficulty
- Angina pectoris/chest pain
- Swollen ankles
- Irregular or rapid heart beats
- Stroke

Respiratory Disorders:

Yes No

- Emphysema or asthma
- Hay fever
- Chronic cough or bronchitis
- Tuberculosis
- Chronic sinusitis
- Breathing problems

Muscular-Skeletal/CNS

Developmental Disorders:

Yes No

- Frequent headaches
- Fainting spells
or loss of consciousness
- Seizures or epilepsy
- Visual impairment
- Hearing impairment
- Artificial joint
- Arthritis or bone disease
- Muscle disease
- Spinal cord injury or paralysis
- Cerebral palsy
- Mental retardation/autism
- Alzheimer's disease or
other dementia

Other information not listed relevant
to your dental care Yes No

Gastrointestinal/

Genitourinary Disorders:

Yes No

- Colitis or ulcers
- Hepatitis
- If yes type:
- Jaundice
- Renal dialysis/transplant
- Kidney disease
- Syphilis, gonorrhea or other
sexually transmitted disease
- Genital herpes
- Frequent canker sore
- Chronic diarrhea
- Frequent vomiting

Hematologic/ Endocrine/

Immune Disorders:

Yes No

- Blood transfusion
- Anemia/leukemia/lymphoma
- Hemophilia
- Sickle Cell Disease
- Blood clots or thrombosis
- Diabetes
- If yes type:
- Thyroid disease
- Adrenal gland disease
- HIV
- AIDS
- Kaposi's Sarcoma
- Bleeding or bruising easily
- Sudden weight loss or gain
- Frequent thirst
- Frequent hunger
- Frequent urination
- Systemic lupus

Psychiatric:

Yes No

- Nervousness
- Depression
- Anxiety
- Past/present psychiatric
treatment

**Family history (Grandparents,
Parents, Sisters, Brothers,**

Children):

Yes No

- Diabetes
- Heart Disease
- Bleeding disorder
- Cancer

Allergies:

Yes No

- Penicillin
- Sulfa drugs
- Novocaine/Xylocaine/
dental anesthetics
- Aspirin
- Codeine
- Latex products
- Others: _____

Females:

Yes No

- Pregnant
- Taking birth control
- Anticipate becoming pregnant
- Breast feeding

Cancer:

Yes No

- Diagnosis _____
Year _____
- Surgery
- Radiation
- Chemotherapy _____

Medications:

Yes No

- _____

Social history:

Yes No

- Smoking years
- Alcohol years
- Substance abuse years

I certify that the above information is correct to the best of my knowledge. I agree to keep this office informed of any changes in my health or any medical conditions I may be taking.

SIGNED _____ **DATE** _____