Medical History

Name: ____

All questions asked on this history form are important in arriving at a diagnosis and treatment plan; all questions must be answered. If any question is not understood, please ask for an explanation. The back of this form may be used if more space is needed for answers.

1. Are you having pain or discomfort at this time? …………………………………………………………………… YES NO
2. Have you been a patient in the hospital during the past year? Why? ………………………………………… YES NO
3. Have you been under the care of a medical doctor during the past year? Why? ……………………………… YES NO
4. Are you currently taking any medications on a regular basis? Please list them. ……………………………… YES NO
5. Are you allergic (itching, rash, swelling) to penicillin, aspirin, codeine, or other drugs? ……………………… YES NO
6. Have you ever had excessive bleeding requiring special treatment? ………………………………………… YES NO
7. Do you have a heart condition that requires antibiotic coverage before dental work? ……………………… YES NO
8. Circle any of the following which you have had or have at present:

Heart Failure	Heart Surgery	Diabetes	Liver Disease
Heart disease or Attack	Artificial Joint	Thyroid Disease	Blood Transfusion
Angina Pectoris	Anemia	Pain in Jaw Joints	Drug Addiction
High Blood Pressure	Stroke	Ulcers	Hemophilia
Hay Fever	Kidney Trouble	STD, Venereal Disease	Rheumatic Fever
Emphysema	Chemotherapy	Bruise Easily	Congenital Heart Lesions
Cough	Arthritis	Cold Sores	Scarlet Fever
Tuberculosis (TB)	Rheumatism	Epilepsy or Seizures	Artificial Heart Valve
Asthma	Cortisone Medication	Fainting or Dizzy Spells	X-ray or Cobalt Treatment
Yellow Jaundice	Glaucoma	Nervousness	Heart Pacemaker
Sinus Trouble	Hepatitis A	Psychiatric Treatment	HIV / AIDS
Allergies or Hives	Hepatitis B	Sickle Cell Disease	Migraine Headaches

9. Do you ever wake up at night with tooth pain? …………………………………………………………………… YES NO
10. Do you have clicking or popping in the jaw joint (TMJ)? ……………………………………………………… YES NO
11. Do you have or have you ever had periodontal (gum) disease? When? …………………………………… YES NO
12.. Have you ever been exposed to AIDS or HIV? ………………………………………………………………… YES NO
13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath or because you are very tired? ……………………………………………………… YES NO
14. Do you have difficulty swallowing or have a chronic sore throat? ……………………………………………… YES NO
15. Have you had unexplained weight loss during the past year? ……………………………………………… YES NO
16. Do you ever wake up from sleep short of breath? ………………………………………………………………… YES NO
17. Are you on a special diet for any reason? ……………………………………………………………………… YES NO
18. Has your physician ever said you have a cancer or tumor? …………………………………………………… YES NO
19. Have you ever taken bisphosphonate drugs for your bones? (Fosamax, Actonal, Boniva, Zometa or Aredia) ……………………………………………………………… YES NO
20. Do you have any disease, condition or problem not listed? …………………………………………………… YES NO
21. WOMEN: Are you pregnant now or anticipate becoming pregnant in the near future? ……………………… YES NO
    Are you practicing birth control? ……………………………………………………………………………… YES NO

To the best of my knowledge, all of the preceding answers are true and correct, and I understand the questions. I authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. If I ever have a change in my health, or if my medications change, I will inform the dentist at the next appointment without fail. I understand that I have the option of having root canals, oral surgery, prosthodontic or orthodontic work done by a specialist.

Date	Signature of Patient or Guardian. (Sign again at each checkup)	Date	Signature of Patient or Guardian
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