MEDICAL HISTORY FORM

Name: _____ Nickname _____ Date: _____ Home: _____
Address: _____ Zip _____ Cell: _____
Email: _____
Date of Birth: _____ SS# _____ Sex: M / F Height: _____ Weight: _____

For the following questions, circle yes or no, whichever applies.
Your answers are for our records only and will be kept confidential.

1. Has there been any change in your health in the past year? ..... Yes No
2. My last physical exam was on _____/_____ .....
3. Name of Medical Physician_____
   Conditions being treated for? _____ MC _____ ASA ____ BMI _____
4. Have you had any serious illness, operation or hospitalization? ..... Yes No
   If so, please list_____
5. Do you or any family member have a history of problems with anesthesia? ..... Yes No
6. Have you had an artificial joint replacement? (knee, hip, shoulder, etc) ..... Yes No
7. Are you taking or have you taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Reclast, Aredia or Zometa)? ..... Yes No
8. Are you taking any medicine(s) ..... Yes No
   If so, please list: _____
   _____
9. Pharmacy: _____

10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmurs? ..... Yes No
    b. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition? ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after climbing 2 flights of stairs? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    c. Sinus trouble ..... Yes No
    d. Asthma, hay fever or seasonal allergies ..... Yes No
    e. Sleep Apnea ..... Yes No
    f. Fainting spells or seizures ..... Yes No
    g. Diabetes ..... Yes No
    h. Hepatitis, jaundice or liver disease ..... Yes No
    i. Thyroid problems ..... Yes No
    j. Respiratory problems, emphysema, bronchitis, etc ..... Yes No
    k. Arthritis or painful, swollen joints including jaw joint(TMJ) ..... Yes No
    l. Osteoporosis ..... Yes No
    m. Stomach ulcer or hyperacidity ..... Yes No
    n. Kidney disease ..... Yes No
    o. Tuberculosis ..... Yes No
    p. Persistent cough or cough that produces blood ..... Yes No
    q. Persistent swollen neck glands ..... Yes No
    r. Low blood pressure ..... Yes No
    s. Epilepsy or neurological disorder ..... Yes No
    t. Cancer ..... Yes No
    u. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to the following?: Please note reaction:
    a. Local Anesthetics (Novocaine) ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other ..... Yes No
16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
17. Do you have any other condition or disease you think the doctor should know about? .. Yes No
    If so, explain: _____
18. Do you smoke any type of cigarettes, cigars, marijuana or chew tobacco? ..... Yes No
    How much?: _____
19. How much alcohol do you drink?_____ Type?_____
20. Do you have a past or present chemical dependency, alcohol or emotional disorder?
    (ex: anxiety, depression, ADHD, etc.) ..... Yes No
21. Are you wearing contact lenses? ..... Yes No
22. Are you wearing removable dental appliances? ..... Yes No

Women

23. Are you pregnant or trying to become pregnant? ..... Yes No
24. Do you have problems associated with your menstrual period? ..... Yes No
25. Are you nursing? ..... Yes No
26. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint: _____
Referring Doctor: _____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ Patient's Signature: _____
Doctor's Signature: _____

DENTAL INSURANCE

Primary Insurance Company_____
Address_____ Telephone Number _____
Insured's Name _____ Group Number _____
Insured's Birthdate _____ Relationship _____
Insured's Employer _____ Social Security #/ ID # _____

MEDICAL INSURANCE

Primary Insurance Company_____
Address_____ Telephone Number _____
Insured's Name _____ Group Number _____
Insured's Birthdate _____ Relationship _____
Insured's Employer _____ Subscriber ID # _____