PATIENT MEDICAL HISTORY

Please print legibly

Salutation: First Name:	Last Name:	M.I.:
Home Phone: ( )	Cell Phone: ( )	Date of Birth:
Work Phone: ( )	Fax: ( )	Gender:
Home Address:	City/State/Zip:	
Employer Name:	Occupation:	
Employer Address:	Social Security Number:	
Referring Doctor:	Family Dentist:	
Family Physician:	Family Physician Phone: ( )	
Guarantor:	Date of Last Physical Exam:: / /	
Home E-mail:	Work E-mail:	
Insurance Company:	Address:	
Subscriber's Name:	Subscriber's ID#:	
Subscriber's DOB:	Group#: Relationship:	

	Yes	No	Don't Know
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.			
2. Has there been any change in your general health within the past year? If yes, please explain.			
3. Are you under the care of a physician for a current problem? If yes, please explain.			
4. Have you been hospitalized within the past 5 years? Please specify.			
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics, antibiotics, medications?			
7. Is there any condition concerning your health that the doctor should be told?			
8. Do you wish to speak to the doctor privately about anything?			
9. Have you had abnormal bleeding with previous extractions, surgery or trauma?			
10. Have you ever required a blood transfusion?			
11. Have you ever had radiation for any condition?			
12. Have you ever tested positively for HIV infections or AIDS? If so, state date diagnosed and treated.			
13. Are you required to take antibiotics prior to dental treatment?			

14. Do you have or have you had any of the following?

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve
- ☐ Join prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Cardiovascular disease; heart attack, stroke or bypass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g. anemia)
- ☐ Venereal disease
- ☐ Asthma
- ☐ Allergy to latex
- ☐ Low blood pressure
- ☐ Swollen ankles, arthritis, or joint disease
- ☐ Cardiac pacemaker
- ☐ Heart surgery
- ☐ Delay in healing
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Kidney problems
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Low blood sugar
- ☐ Dialysis
- ☐ Irregular heart beat
- ☐ Contagious diseases
- ☐ Bronchitis, chronic cough
- ☐ Hay fever or sinus problems

- ☐ Tuberculosis
- ☐ Emphysema
- ☐ X-Ray treatment or chemotherapy
- ☐ On a diet
- ☐ History of alcohol abuse
- ☐ Eye disease or glaucoma
- ☐ Infectious mononucleosis
- ☐ Problems with the immune system
- ☐ Difficult breathing or other lung trouble
- ☐ Chronic fatigue or night sweats
- ☐ History of drug abuse
- ☐ Wear contact lenses
- ☐ Bruise easily
- ☐ Gallbladder trouble

	Yes	No	Don't Know
15. Are you taking any herbal medicine (i.e., St. John's Wort)?			
16. Have you ever taken the "fen-phen" diet pill?			
17. Do you have any disease, condition or problem not listed above? Specify.			
18. Are you taking biophosphonates now or have you taken them in the past (Fosamax)?			
19. Are you taking any medication or drugs? If yes, please list them below.			

Women Only:

Possibility of pregnancy:	YES/NO	Nursing:	YES/NO
If yes, estimated delivery date:	YES/NO	Taking birth control pills:	YES/NO

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

Injury:

This visit is related to an accident:	YES/NO	Work related:	YES/NO
Date of injury:			
Insurance company handling the claim:			
Claim Number:			

_____ _____

Patient Signature (Parent signature if patient is under 18 years of age) **Date**