MEDICAL HISTORY FORM

Date________________________________
Name _______________________________
Date of Birth _________________________

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

1. Are you in good health?.. Yes No
2. Has there been any change in your health since last year?.. Yes No
3. My last physical exam was on _______________
4. Are you now under the care of a physician?.. Yes No
   If so, for what conditions? ____
   ____
   ____
5. The name and address of my physician is: ____________________________________
   ____
   ____
6. Have you had any serious illness, operation or hospitalization within the past 5 years?........................ Yes No
   ____
7. Are you taking any medicine(s), including non-prescription?.. Yes No
   If so, please list the names and dosages: ______________________ ______________________
   ______________________ ______________________
   ______________________ ______________________
   ______________________ ______________________
8. Have you had an allergic reaction or serious side effect to any medication?........................ Yes No
   If so, please specify: ____
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or murmur.. Yes No
   b. Rheumatic Heart Disease.. Yes No
   c. Heart trouble, heart attack, angina, arteriosclerosis or any other heart condition........................ Yes No
      1. Chest pain on exertion?.. Yes No
      2. Shortness of breath after mild exercise?.. Yes No
      3. Do your ankles swell?.. Yes No
   d. High blood pressure or stroke.. Yes No
   e. Fainting spells or seizures.. Yes No
   f. Asthma.. Yes No
   g. Diabetes.. Yes No
   h. Hepatitis, jaundice or liver disease.. Yes No
   i. Frequent or recurring mouth sores.. Yes No
   j. Thyroid problems.. Yes No
   k. Allergies or hay fever.. Yes No
   l. Respiratory problems emphysema, bronchitis, etc.. Yes No
   m. Arthritis or painful, swollen joints.. Yes No
   n. Stomach ulcer, esophageal reflux or hiatal hernia.. Yes No
   o. Kidney trouble.. Yes No
   p. Tuberculosis.. Yes No
   q. Persistent cough or cough that produces blood.. Yes No
   r. Persistent swollen neck glands.. Yes No
   s. Low blood pressure.. Yes No
   t. Epilepsy or neurological disorder.. Yes No
   u. Problems with anxiety, nerves or mental health.. Yes No
   v. Cancer.. Yes No
   w. Problems of the immune system.. Yes No
10. Have you had abnormal bleeding?.. Yes No
    a. Have you ever required a blood transfusion?.. Yes No
11. Do you have any blood disorder such as anemia?.. Yes No
12. Have you ever had treatment for a tumor or growth?.. Yes No
13. Have you had any serious trouble associated with previous dental treatment?........................ Yes No
    If so, explain ____
    ____

14. Do you have any other condition or disease you think I should know about?..Yes No
If so, explain ____

____

15. Are you wearing contact lenses?..Yes No
16. Are you wearing removable dental appliances?...Yes No
17. Do you consume alcohol? If so, how much? ___________________________………………………………….. Yes No
18. Do you use cigarettes or other tobacco products?……………………………………………………………………………Yes No
19. Do you use street drugs or alternative medical treatments?……………………………………………………………… Yes No

Women

20. Are you pregnant?..Yes No
21. Do you have problems associated with your menstrual period?..Yes No
22. Are you nursing?...Yes No
23. Are you taking birth control pills?...Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of Patient

Medical History Update:

Date:	**Comments:**	**Signature:**