**FOR COMPLETION BY DENTIST ONLY**

Significant findings from questionnaire or oral interview concerning medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dental management considerations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Date Signature of Dentist

**Medical History Update**

 Date Changes/Comments Patient Signature Dentist Initials

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**Medical History Form**

**PLEASE BEGIN HERE** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following questions, circle *yes* or *no*, according to the appropriate answer. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked questions about your responses to this questionnaire, and there may be additional questions concerning your health.

1. Are you in good health? Yes No

2. Has there been any change in your general health within the past year? Yes No

3. My last physical examination was on

4. Are you now under the care of a physician? Yes No

 a. If so, what is the condition being treated?

5. The name and address of my physician(s) is:

6. Have you had a serious illness, operation, or been hospitalized in the past 2 years? Yes No

 a. If so, what was the illness or problem?

7. Are you taking any medicine(s) including non-prescription medicine? Yes No

 a. If so, what medicine(s) are you taking?

8. Are you currently using or have you ever used any tobacco products or alcohol? Yes No

 a. If yes, explain.

9. Have you ever taken any of the following diet drugs:

 a. Fen-Phen Yes No

 b. Pondimin Yes No

 c. Redux Yes No

 d. If so, have you had a medical exam to ensure that your heart valves were not affected? Yes No

10. Do you have or have you had any of the following diseases or problems?

 a. Damaged or artificial heart valves Yes No

 b. Heart murmur or rheumatic heart disease Yes No

 c. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arterio-

 sclerosis, stroke) Yes No

 1. Do you have chest pain upon exertion? Yes No

 2. Are you ever short of breath after mild exercise or when lying down? Yes No

 3. Do your ankles swell? Yes No

 4. Do you have inborn heart defects? Yes No

 5. Do you have a cardiac pacemaker? Yes No

 d. High Blood Pressure Yes No

 e. Glaucoma Yes No

 f. Asthma, hay fever or sinus trouble Yes No

 g. Fainting spells or seizures Yes No

 h. Persistent diarrhea or recent weight loss Yes No

 i. Diabetes Yes No

 j. Hepatitis, jaundice or liver disease Yes No

 k. AIDS or HIV infection Yes No

 l. Thyroid problems Yes No

 m. Respiratory problems, emphysema, bronchitis, etc Yes No

 n. Arthritis or painful, swollen joints Yes No

 o. Stomach ulcer or hyper acidity Yes No

 p. Kidney trouble Yes No

 q. Tuberculosis Yes No

 r. Persistent cough or cough that produces blood Yes No

 s. Persistent swollen glands in neck Yes No

 t. Low blood pressure Yes No

 u. Sexually transmitted disease Yes No

 v. Epilepsy or other neurological disease Yes No

 w. Problems with mental health or nervous breakdown Yes No

 x. Cancer, Chemotherapy, or Radiation Yes No

 y. Problems of the immune system Yes No

 z. Osteoporosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

11. Have you had abnormal bleeding? Yes No

 a. Have you ever required a blood transfusion? Yes No

12. Do you have a blood disorder such as anemia? Yes No

13. Have you ever had any treatment for a tumor or growth? Yes No

14. Are you allergic or have you had a reaction to:

 a. Local anesthetics Yes No

 b. Penicillin or other antibiotic Yes No

 c. Sulfa drugs Yes No

 d. Barbiturates Yes No

 e. Aspirin Yes No

 f. Iodine Yes No

 g. Codeine or other narcotics Yes No

 h. Latex Yes No

 i. Other Yes No

15. Have you had any serious trouble associated with dental treatment? Yes No

 a. If so, explain.

16. Have you ever had a skin rash or other reaction to metal jewelry? What metal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

17. Do you have any disease, condition, or problem not listed that you think I should know about? Yes No

 a. If so, explain.

18. Are you wearing contact lenses? Yes No

19. Are you wearing removable dental appliances? Yes No

20. Have you ever had an artificial joint, pin, plate, or other device surgically implanted? Yes No

21. Have you ever received counseling for excessive use of alcohol and or prescription drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

22. Have you ever been involved with dental/medical legal activity?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

WOMEN ONLY

20. Are you pregnant? Yes No

21. Do you have any 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 dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_