MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking?

_____

_____

4. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO	
☐	☐	Local anesthetics	☐	☐	Latex
☐	☐	Aspirin	☐	☐	Penicillin/antibiotics
☐	☐	Sedatives	☐	☐	Other
☐	☐	Sulfa drugs	☐	☐	Iodine

5. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

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

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack if so, when ___	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur Pre-Med? ___	☐	☐	Stroke if so, when ___
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies
☐	☐	Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy, When ___
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy/Convulsions	☐	☐	Cancer if so, type _____	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis/Jaundice (A,B,or C)	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers			

7. Dental History

YES	NO		YES	NO	
☐	☐	Are your teeth sensitive to hot or cold?	☐	☐	Do you feel pain in your teeth?
☐	☐	Are your teeth sensitive to biting?			
☐	☐	Do you have any sores or lumps in or near your mouth?			
☐	☐	Do you clench or grind your teeth?			

Reason for today's visit: _____ Date of last visit: _____

Have you had any recent dental work done in the area of concern? If so, please explain: _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT OR GUARDIAN **DATE**