MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM _____

PHYSICIAN(S) NAME _____ SPECIALIST NAME _____

ADDRESS _____ ADDRESS _____

PHONE NUMBER _____ PHONE NUMBER _____

INDICATE ☑ YES OR ☑ NO IF YOU HAVE OR HAD ANY OF THE FOLLOWING.

YES NO

☐ ☐ 1. Are you in good health?

☐ ☐ 2. Are you now under the care of a physician?
If so, what are the conditions being treated? _____

☐ ☐ 3. Have you had any serious illness, operation, or been hospitalized in the last 5 years?
If so, what was the illness or problem? _____

☐ ☐ 4. Are you taking any medicine(s) including non-prescription medicine?
If so, what medicine(s) are you taking? _____

☐ ☐ 5. Do you have any prosthetic joints? _____ Year placed _____

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

☐ ☐ a. Congenital heart disease, rheumatic heart disease, infective endocarditis, prosthetic heart valve, or coronary artery stent

☐ ☐ b. Cardiovascular disease including hypertension, angina, heart attack, cardiac arrhythmia, heart failure, or stroke

☐ ☐ 1. Do you experience fatigue, shortness of breath, or chest pain with moderate physical activity?

☐ ☐ 2. Do you have marked limitation of activity due to fatigue, shortness of breath or chest pain but are comfortable at rest?

☐ ☐ 3. Do you have an implanted pacemaker?

☐ ☐ c. Have you ever had a reaction to local anesthetic (novocaine), penicillin, aspirin, iodine, or any other medicines?

☐ ☐ d. Allergies (environmental, food, metals, jewelry, latex rubber, sunscreen lotions, sulfites or other substances)

☐ ☐ e. Addiction to alcohol or use any of the following: marijuana, opioids, methamphetamines, benzodiazepines, cocaine, "club drugs"

☐ ☐ f. Chronic sinus problems

☐ ☐ g. Obstructive sleep apnea

☐ ☐ h. Asthma or COPD (Chronic bronchitis, emphysema)

☐ ☐ i. Low blood pressure, syncope (fainting)

☐ ☐ j. Thyroid problem: ☐ Hypothyroidism ☐ Hyperthyroidism

☐ ☐ k. Kidney disease

☐ ☐ l. Liver disease, hepatitis, jaundice

☐ ☐ m. Diabetes: ☐ Type I ☐ Type II

☐ ☐ n. Tuberculosis or persistent cough that produces blood

☐ ☐ o. AIDS or HIV infection

☐ ☐ p. Sexually transmitted disease

☐ ☐ q. GERD (Gastroesophageal Reflux Disease), stomach ulcer, colitis, Celiac disease

☐ ☐ r. Dementia, Alzheimer's disease, cognitive disorders

☐ ☐ s. Epilepsy or other neurological disease

☐ ☐ t. Treatment for a growth or cancer

☐ ☐ u. Problems with mental health, anxiety or depression

☐ ☐ v. Blood disorder such as anemia or hemophilia

☐ ☐ w. Abnormal or prolonged bleeding or bruise easily

☐ ☐ x. Gout, systemic lupus erythematosus, Sjögrens syndrome

☐ ☐ y. Rheumatoid arthritis, osteoarthritis, osteopenia, osteoporosis

☐ ☐ z. Have you ever taken medication to prevent bone loss or bone tumors?

☐ ☐ aa. Other medical condition not listed above: _____

☐ ☐ 7. Have you had any serious trouble associated with any previous dental treatment? If so, explain _____

WOMEN

☐ ☐ 8. Are you pregnant? If yes, due date: _____

☐ ☐ 9. Are you nursing?

☐ ☐ 10. Are you taking birth control pills?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires 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 PATIENT (PARENT, GUARDIAN) _____ **DATE** _____
mo. day yr.

For completion by the dentist:

SIGNIFICANT FINDINGS _____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	SIGNATURE