MEDICAL HISTORY

Patient's Name:_____ Age:_____ Chart #:_____

Is patient in good health? □ Yes □ No If No, explain_____

Physician's Name:_____ Phone Number:_____

Is patient under a physician's care now? □ Yes □ No If Yes, explain_____

1. Is patient taking any prescribed or over-the-counter medication? Birth control medications?..... □ Yes □ No
2. If Yes, list medications:_____
3. Is the patient pregnant?_____ If so, how many month?_____
4. Has patient ever had a blood transfusion?..... □ Yes □ No
5. Does the patient smoke? □ Yes □ No Use tobacco? □ Yes □ No Use recreational drugs?..... □ Yes □ No
6. Has the patient ever had an allergic reaction to local anesthetic (e.g. novacaine)?..... □ Yes □ No
7. Is the patient allergic to any medication (e.g. penicillin)?..... □ Yes □ No
8. Is the patient allergic to latex?..... □ Yes □ No
9. Has the patient ever had prolonged bleeding after an injury or extraction?..... □ Yes □ No
10. Does the patient have a cardiac pacemaker or artificial heart valve?..... □ Yes □ No
11. Is there any family history of diabetes, heart murmur/problems, tumors?..... □ Yes □ No
12. Does the patient's jaw pop or click when chewing? (TMJ)..... □ Yes □ No
13. Are you pleased with the appearance of your smile?..... □ Yes □ No
14. If no, explain_____
15. Does the patient have any missing teeth? □ Yes □ No If yes, does the patient have an appliance?..... □ Yes □ No
16. What type?_____ Year made_____ Is it comfortable?..... □ Yes □ No
17. What is your chief complaint?_____
18. What would you like to discuss with the dentist today? □ Toothache □ Cosmetic Surgery □ Orthodontics (Braces)
    □ Routine Dental Checkup □ Crowns/Bridges □ Gum Problems □ Partials/Dentures □ Replacing Missing Teeth
    □ Removal of Wisdom Teeth □ Oral Surgery □ Estimate □ Second Opinion
19. Please check each box, yes or no, if the patient has ever had any illness or conditions listed below. Please answer all questions.

Y	N		Y	N		Y	N		Y	N	
□	□	AIDS/HIV	□	□	Allergies	□	□	Anemia	□	□	Thyroid Problems
□	□	Arthritis	□	□	Artificial Joint	□	□	Asthma	□	□	Bleeding Disorders
□	□	Cancer	□	□	Chemotherapy	□	□	Cold Sores	□	□	Diabetes
□	□	Dizzy Spells	□	□	Emphysema	□	□	Epilepsy	□	□	Emotional Disorder
□	□	Fainting	□	□	Fever Blisters	□	□	Glaucoma	□	□	Heart Attack
□	□	Heart Bypass	□	□	Heart Murmur	□	□	Heart Problems	□	□	Immunosuppressed
□	□	Hepatitis	□	□	High Blood Pressure	□	□	HIV Positive	□	□	Low Blood Pressure
□	□	Jaundice	□	□	Kidney Disease	□	□	Liver Problems	□	□	Radiation Therapy
□	□	Lung Disease	□	□	Nervous/Mental Disorder	□	□	Psychiatric Treatment	□	□	Medication Containing Bisphosphonates
□	□	Rheumatic Fever	□	□	Sinus Trouble	□	□	Stroke			
□	□	Tuberculosis	□	□	Venereal Disease	□	□	Mitral Valve Prolapse	□	□	Artificial Heart Valve
□	□	Cardiac Pacemaker	□	□	Use of Fen-Phen	□	□	Angina			

20. Has patient had any disease, serious illness/surgery, condition or problem not listed above. □ Yes □ No If Yes, explain:_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

_____ _____

Patient's Signature/responsible party if patient is a minor Date

For Doctors Use Only

Health History Reviewed By_____(Doctor's Signature) Date:_____

Comments:_____

RECALL REVIEW: 6 MONTH

Any changes in health history □ No □ Yes, please list changes_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

RECALL REVIEW: 12 MONTHS

Any changes in health history □ No □ Yes, please list changes_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

RECALL REVIEW: 18 MONTHS

Any changes in health history □ No □ Yes, please list changes_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

RECALL REVIEW: 24 MONTHS

Any changes in health history □ No □ Yes, please list changes_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____