

# MEDICAL HISTORY

Age \_\_\_\_\_ **CIRCLE ONE**

- |  |     |    |
|--|-----|----|
| 1. Are you having pain or discomfort at this time? . . . . .   | Yes | No |
| 2. Do you feel very nervous about dentistry treatment? . . . . .   | Yes | No |
| 3. Have you ever had a bad experience in the dental office? . . . . .  | Yes | No |
| 4. Have you been a patient in the hospital during the last two years? . . . . .  | Yes | No |
| 5. Have you been under the care of a medical doctor during the last two years? . . . . .   | Yes | No |
| 6. Have you taken any medicine or drugs during the last two years? . . . . .   | Yes | No |
| 7. Are you allergic to (i.e., itching, rash, swelling of the hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? If so, to what? . . . . . | Yes | No |
| 8. Have you ever had any excessive bleeding requiring special treatment? . . . . .   | Yes | No |

\_\_\_\_\_  
Physicians Name/Phone #

\_\_\_\_\_  
Pharmacy Choice/Phone #

- |  |     |    |
|--|-----|----|
| 9. Are you taking any medication? <i>(If yes, please list type and dose)</i> . . . . . | Yes | No |
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**Circle any of the following which you have had, or have at the present, or hope to have in the future:**

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|-------------------------------|--|---------------------------------------|
| AIDS (or ARC)                 | Emphysema                                  | Mitral Valve Prolapse                 |
| Allergies or Hives            | Epilepsy or Seizures                       | Osteoporosis                          |
| Alzheimers or Mental Disorder | Fainting, Dizzy Spells                     | Pacemaker                             |
| Anemia                        | Heart Failure                              | Pain in Jaw Joints                    |
| Angina Pectoris               | Heart Disease or Attack                    | Rheumatic Fever                       |
| Arthritis/Fibromyalgia        | High Blood Pressure                        | Radiation or Chemotherapy Treatment   |
| Artificial Heart Valve        | Heart Murmur                               | Scarlet Fever                         |
| Artificial Joint              | Heart Surgery                              | Stroke                                |
| Asthma                        | Hearing Problems                           | Sinus Troubles                        |
| Bruise Easily                 | Hepatitis A, B, C, D (circle what applies) | Tuberculosis (TB)                     |
| Congenital Heart Lesions      | Hemophilia                                 | Thyroid Disease                       |
| Cancer/Leukemia               | Kidney Trouble                             | Venereal Disease                      |
| Cold Sores                    | Liver Disease                              | (Syphilis, Genital Herpes, Gonorrhea) |
| Diabetes                      | Long and Happy Life                        | Yellow Jaundice                       |
| Drug Addiction                | Lung Disorder                              | Other _____                           |

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| 10. When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? . . . . . | Yes | No |
| 11. Do your ankles swell during the day? . . . . .   | Yes | No |
| 12. Have you lost or gained more than 10 pounds in the last year? . . . . .  | Yes | No |
| 13. Do you ever wake up from sleep short of breath? . . . . .  | Yes | No |
| 14. Are you on a special diet? . . . . .   | Yes | No |
| 15. Do you have any disease, condition, or problem not listed? . . . . .   | Yes | No |
| 16. <b>WOMEN:</b> Are you pregnant now? . . . . .  | Yes | No |
| Are you practicing birth control? . . . . .  | Yes | No |
| Do you anticipate becoming pregnant? . . . . .   | Yes | No |

To the very best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

|                    |               |                       |
|--------------------|---------------|-----------------------|
| _____<br>Signature | _____<br>Date | _____<br>BP and Pulse |
|--------------------|---------------|-----------------------|