

Medical History

Patient Name

DOB

Are you having pain or discomfort at this time?

Y N

Do you feel very nervous about having dental treatment?

Y N

Have you ever had a bad experience in a dental office?

Y N

Have you been a patient in the hospital during the past two years?

Y N

Have you been under the care of a medical doctor during the past two years?

Y N

Have you taken any medicine or drug during the past two years?

Y N

If so, what?

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? If so, what?

Y N

Have you previously had any excessive bleeding that required special treatment?

Y N

Check any of the following, which you have had or have presently:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Angina Pectoris (Chest Pain) | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cortizone Medicine | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Radiation or Cobalt | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Artificial Heart Lesions | <input type="checkbox"/> Cough | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> AIDS Related complex (ARC) | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Asthma | <input type="checkbox"/> AIDS | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Congenital Defects/Valve | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hepatitis A (infectious) | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hepatitis B (sarum) | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |

When you walk up 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?

Y N

Do your ankles swell during the day?

Y N

Have you lost or gained more than 10 pounds in the past year?

Y N

Do you ever wake up from sleep short of breath?

Y N

Are you on a special diet?

Y N

Has your medical doctor ever said you have cancer or a tumor?

Y N

Do you have any disease, conditions, or problems not listed?

Y N

If yes, please list:

Have you ever had a tonsillectomy? (Had your tonsils taken out?)

Y N

Please check any of the following childhood diseases you have had? None

- | | | | |
|--|--------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Scarletina | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Tonsillitis |

Do you use any of the following products? (please check) None

- | | | |
|--|----------------------------------|---------------------------------|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cigars |
| <input type="checkbox"/> Chewing Tobacco | <input type="checkbox"/> Pipe | <input type="checkbox"/> Snuff |

When was your last dental cleaning/exam/x-rays?

Is there anything you would like to change about your smile?

Women:

Are you pregnant now?

Y N

Are you taking birth control pills?

Y N

Do you anticipate becoming pregnant?

Y N

Use the button to the right to print your form once you have filled it out. >>

Print Form