MEDICAL HISTORY FORM

Date_____

Name_____ Date of Birth____/____/____ Sex M F
Last First Middle mo day yr

For the following questions, *circle yes or no*, which ever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. Date of last physical examination_____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated?_____
5. The name and address of your physician(s)_____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
   If so, what was the illness or problem?_____
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
   List medications_____
   _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease..... Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
      1. Do you have chest pain upon exertion? ..... Yes No
      2. Do you have heart defects? ..... Yes No
      3. Do you have cardiac pacemaker..... Yes No
   c. Do you require premedication before dental trmt due to your cardiovascular disease or joint replacement surgery? Yes No
   d. Sinus trouble..... Yes No
   e. Asthma or hay fever..... Yes No
   f. Fainting spells or seizures..... Yes No
   g. Persistent diarrhea or recent weight loss..... Yes No
   h. Diabetes..... Yes No
   i. AIDS or HIV infection..... Yes No
   j. Respiratory problems, emphysema, bronchitis, etc..... Yes No
   k. Arthritis or painful swollen joints..... Yes No
   l. Stomach ulcer or hyperacidity..... Yes No
   m. Kidney trouble..... Yes No
   n. Tuberculosis..... Yes No
   o. Persistent swollen glands in neck..... Yes No
   p. Low blood pressure..... Yes No
   q. Sexually transmitted disease..... Yes No
   r. Epilepsy or other neurological disease..... Yes No
   s. Problems with mental health..... Yes No
   t. Cancer..... Yes No
   u. Problems of the immune system..... Yes No
9. Have you had abnormal bleeding? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you ever had any treatment for a tumor or growth? ..... Yes No
12. Have you ever taken any diet medication such as Phen/Fen? ..... Yes No
13. Are you allergic or have you had a reaction to:
    Local anesthetic..... Yes No
    Penicillin or other antibiotics..... Yes No
    Sulfa drugs..... Yes No
    Barbiturates, sedatives, or sleeping pills..... Yes No
    Aspirin..... Yes No
    Iodine..... Yes No
    Codeine..... Yes No
    Latex – Dental materials or solutions – if so, explain_____ Yes No

Please list any other allergies not listed _____

14. Have you had any trouble associated with any previous dental treatment? ..... Yes No
    If so, explain _____ Yes No
15. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
    If so, explain _____ Yes No
16. Have you ever taken medication for Osteoporosis? ..... Yes No
16. Are you wearing any removable dental appliances? ..... Yes No
17. a. Do you use tobacco? ..... Yes No
    b. Do you use cocaine or other drugs? ..... Yes No
    c. Do you use alcohol? ..... Yes No
    If so, how often? _____
    d. Have you ever been treated for alcoholism or chemical dependency? ..... Yes No

18. Do you snore or has anyone ever told you that you snore? ..... ***Yes No***
19. Is your snoring bothersome for your bed partner? ..... ***Yes No***
20. Has anyone reported that you gasp for air, choke, or stop breathing while you sleep? ..... ***Yes No***
21. Would you/your bed partner consider your snoring louder than a person talking? ..... ***Yes No***
22. Do you wake refreshed? ..... ***Yes No***
23. Are you excessively tired during the day? ..... ***Yes No***
24. What is your neck size? (inches) _____
25. Have you previously been diagnosed with Sleep Apnea? ..... ***Yes No***

Women (#23 - #25)

23. Are you pregnant? ..... Yes No
    If so, what is your due date? _____
24. Are you nursing? ..... Yes No
25. Are you taking birth control pills or using Norplant implants or similar devices? ..... Yes No

Check (√) if you have had problems with any of the following

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping
- ☐ Food collection between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose or broken fillings
- ☐ Periodontal treatment
- ☐ Snoring or sleep apnea
- ☐ Sensitivity to hot or cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Authorization and Release

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the periods of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents.

X _____

Signature of patient or parent if minor

For completion by the dentist

Comments on patient interview concerning medical history: _____

_____

_____ _____

(Date) (Signature of Dentist)