

# PATIENT MEDICAL HISTORY

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

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1. Name and address of your physician: \_\_\_\_\_
2. Date of your last physical (month/year): \_\_\_\_\_
3. Are you currently under the care of a physician? Yes No  
If yes, what is the condition being treated? \_\_\_\_\_
4. Have you ever had any serious illness, operation or hospitalization? ----- Yes No  
If yes, please list: \_\_\_\_\_
5. Are you currently taking any medication(s) including non-prescription or herbal supplements? ----- Yes No  
If yes, please list: \_\_\_\_\_
6. Do you have any allergy or sensitivity to any medications and/or anesthetics? ----- Yes No
7. Do you have a latex allergy? ----- Yes No
8. Do you have high or low blood pressure? ----- Yes No  
If yes, which? \_\_\_\_\_
9. Do you have or have you had cardiovascular disease, including heart trouble, heart attack, stroke, angina, irregular heart rhythm or rhythm regulating device (i.e. pacemaker, defibrillator) vascular grafts or shunts, coronary insufficiency/occlusions, congenital heart defect, arteriosclerosis, or heart or blood vessel problems? ----- Yes No  
If yes, which type? \_\_\_\_\_
10. Do you have a damaged or artificial heart valve or a history of heart murmur or rheumatic fever? ----- Yes No
11. Do you have an artificial joint(s), prosthesis, or organ transplant? ----- Yes No  
If yes, which type? \_\_\_\_\_
12. Do you have or have you had cancer? ----- Yes No  
If yes, which type and how was it treated? \_\_\_\_\_

13. Please circle any of the following which you have had or have at present:

- |                                       |                                      |   |
|---------------------------------------|--------------------------------------|---|
| <b>Abnormal Bleeding</b>              | <b>Epilepsy/Neurological Disease</b> | <b>Problems with Mental Health</b>      |
| <b>Anemia</b>                         | <b>Fainting Spells or Seizures</b>   | <b>Recent Unexplainable Weight Loss</b> |
| <b>Arthritis or Painful Joints</b>    | <b>Jaundice/Liver Disease</b>        | <b>Respiratory Problems/Emphysema</b>   |
| <b>Asthma</b>                         | <b>Kidney Problems</b>               | <b>Sexually Transmitted Disease</b>     |
| <b>Blood Disorder</b>                 | <b>Osteoporosis</b>                  | <b>Sinus Problems</b>                   |
| <b>Blood Transfusion – When _____</b> | <b>Persistent Cough</b>              | <b>Stomach Problems</b>                 |
| <b>Bronchitis</b>                     | <b>Problems of the Immune System</b> | <b>Tuberculosis</b>                     |
| <b>Diabetes</b>                       |                                      |   |

14. Do you have or have you had hepatitis? ----- Yes No  
 If yes, which type? \_\_\_\_\_
15. Have you ever been tested for AIDS or HIV infection? ----- Yes No
16. Do you have AIDS or HIV infection? ----- Yes No
17. Do you use or have you used tobacco in any form? ----- Yes No  
 If yes, which type? \_\_\_\_\_
18. Do you have or have you had a history of alcohol and/or drug dependency? ----- Yes No  
 If yes, which type? \_\_\_\_\_
19. Do you have or have you had an eating disorder? ----- Yes No
20. Do you have any other medical disease, condition, or problems not listed? ----- Yes No  
 If yes, please explain: \_\_\_\_\_

**WOMEN ONLY**

21. Are you pregnant? ----- Yes No
22. Are you nursing? ----- Yes No
23. Are you taking birth control? If yes, what? \_\_\_\_\_ Yes No

**DENTAL HISTORY**

1. What is your primary dental concern? \_\_\_\_\_
2. How long since your last dental visit? \_\_\_\_\_
3. Your previous dentist's name? \_\_\_\_\_
4. Have you ever had any unusual problems or complications with previous dental treatment? ----- Yes No  
 If yes, please explain: \_\_\_\_\_
5. Have you ever had gum treatment or surgery? ----- Yes No

**I certify the above information is complete and accurate.**

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**In case of emergency call:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_