Patient Medical History Form

Please note: Prior to any dental treatment, our office requires a complete medical history. Knowing any health problems and/or medications you may be taking can avoid problems when treatment commences. Thank you for taking the time to answer these questions.

	Yes	No
1. Are you in good health?	☐	☐
2. Have there been any changes in your health within the past year?	☐	☐
3. Are you under the care of a physician? If yes, please provide:	☐	☐
Physician's name: _____ Office address: _____ Office phone #: _____		
4. What was the date of your last physical examination? _____		
5. Have you ever been hospitalized for an operation or serious illness? If so, please detail _____	☐	☐
6. Are you taking any medication(s) including non-prescription medication? If so, please list _____	☐	☐
7. Have you ever experienced abnormal bleeding?	☐	☐
8. Do you bruise easily?	☐	☐
9. Have you ever required a blood transfusion?	☐	☐
10. Have you recently had a significant weight loss?	☐	☐
11. Are you taking or have you ever taken Fen-phen or Redux (anti-obesity drugs)?	☐	☐
12. Do you use tobacco? If so, how much (in packs or days)?	☐	☐
13. Have you used any controlled substances within the past 6 months?	☐	☐
14. Are you wearing contact lenses?	☐	☐
15. Do you have any disease, condition, or problem not listed above that you think the dentist should know about?	☐	☐

For Women Only

16. Are you pregnant or think you may be pregnant?	☐	☐
17. Are you nursing?	☐	☐
18. Are you currently taking birth control?	☐	☐

Are you allergic or have you had a reaction to:

Local anesthetics or "freezing"?	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin (ASA)	☐	☐
Metals (e.g., nickel, mercury)	☐	☐
Latex/rubber	☐	☐
Other (please specify)	☐	☐

Do you have or have you ever had the following:

If yes, please circle which condition applies	Yes	No		Yes	No
Rheumatic heart disease or rheumatic fever	☐	☐	AIDS or HIV virus	☐	☐
Scarlet fever	☐	☐	Sexually transmitted diseases	☐	☐
Heart defect, heart murmur, or heart surgery of any kind	☐	☐	Thyroid problems	☐	☐
Heart trouble, heart attack, or angina	☐	☐	Arthritis or rheumatism	☐	☐
Chest pain	☐	☐	Joint replacement or implant	☐	☐
Pacemaker	☐	☐	Stomach ulcer(s)	☐	☐
High/low blood pressure	☐	☐	Kidney trouble	☐	☐
Swelling of feet, ankles, or hands	☐	☐	Tuberculosis	☐	☐
Hepatitis, jaundice, or liver disease	☐	☐	Persistent cough or cough that produced blood	☐	☐
Stroke	☐	☐	Chemotherapy treatment for cancer or leukemia	☐	☐
Sinus trouble	☐	☐	Epilepsy or seizures	☐	☐
Lung, breathing problems, or asthma	☐	☐	Anemia	☐	☐
Hives or skin rash	☐	☐	Glaucoma	☐	☐
Fainting or dizzy spells	☐	☐	Nervousness	☐	☐
Diabetes	☐	☐	Tonsillitis	☐	☐
Hay fever	☐	☐	Mental health issues	☐	☐
Back problems	☐	☐	Chemical dependency	☐	☐

Patient's name (please print): _____ Date: _____

Signature of patient or guardian: _____