Medical History

It is very important to answer all questions truthfully and to the best of your knowledge so that we can best plan your dental care and avoid any unnecessary personal health risks. Please assist us by completing the following, and let us know if you do not understand any part of this form:

Name:				Today's Date:
How do you describe your general health? ☐Excellent ☐Good ☐Fair ☐Poor				What do you consider to be your most important health issues?
Birth date:	Age:	Height:	Weight:	Who is your personal physician? / Physician's telephone:

Have you ever had or been treated for any of the following diseases/conditions? **Please check Yes or No and circle all that apply**. Thank you.

Yes ☐ No ☐ **HEART**
Congestive heart failure
Congenital heart malformation
Valve problems / murmur
Chest pain / angina
Heart attack / myocardial infarct
Cardiac arrhythmia Pacemaker / defibrillator / VAD

Yes ☐ No ☐ **VASCULAR**
High / Low blood pressure
Fainting / dizzy spells
Central venous catheter / PICC
Stroke, TIA

Yes ☐ No ☐ **BLEEDING DISORDERS**
Hemophilia
Anticoagulants
Bruise easily
Low / high platelets
Anemia
Transfusions
Sickle cell disease

Yes ☐ No ☐ **LUNGS**
Asthma, Bronchitis, Emphysema
Pulmonary fibrosis / scarring
Chronic cough, short of breath
Pneumonia, tuberculosis
Obstructive Sleep Apnea

Yes ☐ No ☐ **LIVER**
Hepatitis (A,B,C, Autoimmune)
Jaundice
Cirrhosis, alcoholism

Yes ☐ No ☐ **DIGESTIVE TRACT**
Diet (special/ restricted)
Ulcers / GI Bleeding
Gastric Reflux / Heartburn
Colitis, Crohns, IBS
Constipation / diarrhea
Esophagus disease

Yes ☐ No ☐ **KIDNEY**
Hemodialysis
Peritoneal dialysis
Acute or chronic Renal failure
Polycystic

Yes ☐ No ☐ **HORMONES**
Thyroid problems
Diabetes / Pancreas disease
Pituitary / Adrenal
Gender hormone issues

Yes ☐ No ☐ **MUSCLES/SKELETON**
Osteoporosis
Artificial joints (hip, knee, etc.)
Multiple sclerosis
Myasthenia Gravis Muscular Dystrophy
Trauma
Swollen ankles

Yes ☐ No ☐ **IMMUNOLOGIC**
Lupus
Other autoimmune disease
Immunosuppressive therapy
Use of prednisone or similar

Yes ☐ No ☐ **CANCER** (Type:_____)
Radiation therapy
Chemotherapy
Surgery

Yes ☐ No ☐ **PSYCHIATRIC**
Psychiatric / Psychologic care
Nervous / anxious Depression
Developmental delay / autism Behavior issues
Learning disability
Alzheimer's / Dementia

Yes ☐ No ☐ **NEUROLOGIC**
Seizures / Epilepsy
Parkinson's
Cerebral palsy

Yes ☐ No ☐ **INFECTIOUS DISEASE**
HIV+
Sexually transmitted disease
Other infectious disease

Yes ☐ No ☐ **HEAD**
Sinus trouble / Hay fever
Migraine headaches Cold sores/ fever blisters Vision / hearing impairment

Yes ☐ No ☐ **HABITS**
Tobacco (cigarettes, cigars, snuff)
Alcohol (social, heavy, alcoholism)
Drug abuse (street / prescription)

Women: Some medications used in dentistry will cross the placenta and breast milk, and might affect the unborn fetus. Antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if taking them.

Are you pregnant? ☐Yes,_____Months ☐No ☐Possibly or Not sure

Do you use birth control pills or injection? ☐Yes ☐No

Are you breastfeeding? ☐Yes ☐No

Using hormone replacement therapy (HRT)? ☐Yes ☐No

Please describe any conditions not listed, or use this space to give details about any of your medical issues:

(OVER)

Please list all medications you are currently taking. Be sure to include over-the-counter and herbal products: (attach extra paper if necessary)

Name	Dose / How often	Reason for taking

Please list all operations you have had:

Please list any allergies and/or bad reactions you have had:

☐ **NO KNOWN ALLERGIES**

To what	What happens?	How severe?

Would you care to speak to the dentist privately about any health issues? ☐ ***Yes*** ☐ ***No***

I have read and understand the questions on the health history. I have answered them to the best of my ability.

Signature of patient:	Date:
Signature of Legal Guardian, if applicable:	Date:
Legal Guardian's relationship to patient:	

Doctor's use:	VS: B/P P SpO_2
	Exercise Tolerance (if applicable):