MEDICAL HISTORY FORM

PATIENT NAME: ______________________________ ACCOUNT NUMBER: _____________

	Y	N		Y	N		Y	N
Adenoids removed			Diabetes			Hay fever		
Tonsils removed			Difficulty concentrating			Hearing impairment		
Ever had problems with tonsils			Dizziness			Heart murmur		
Still have tonsils and adenoids			Emphysema			Heart disorder		
Anemia			Epilepsy			Heart pacemaker		
Arteriosclerosis			Excessive thirst			Heart palpitations		
Asthma			Fluid retention			Heart valve replacement		
Autoimmune disorders			Frequent cough			Hemophilia		
Bleeding easily			Frequent illnesses			Hepatitis		
Blood pressure High Low			Frequent stressful situations			Hypoglycemia		
Breathe through mouth often			General anesthesia			Immune system disorder		
Bruising easily			Glaucoma			Injury to		
Bruxing, clenching, grinding			Gout			Face		
Cancer			Habits: Thumb or finger sucking			Mouth		
Chemotherapy			Nail biting			Neck		
Chronic fatigue			Lip biting			Teeth		
Cold hands and feet			Lower lip beneath			Insomnia		
Current pregnancy			upper front teeth			Intestinal disorders		
Depression			Other habits			Jaw joint surgery		
						Kidney problems		
						Liver disease		
						Meniere's disease		

	Y	N		Y	N		Y	N
Menstrual cramps			Parkinson's disease			Speech problems		
Multiple sclerosis			Poor circulation			Stroke		
Muscle aches			Prior orthodontic treatment			Swollen, stiff or painful		
Muscle shaking (tremors)			Psychiatric care			joints		
Muscle spasms or cramps			Radiation treatment			Tendency for:		
Muscular dystrophy			Rheumatic fever			Frequent Colds		
Needing extra pillows to help			Rheumatoid arthritis			Ear Infections		
breathing at night			Scarlet fever			Sore Throats		
Nervous system irritability			Shortness of breath			Tired muscles		
Nervousness			Sinus problems			Tuberculosis		
Neuralgia			Skin disorder			Tumors		
Osteoarthritis			Slow healing sores			Urinary disorders		
Osteoporosis			Snore at night			Wisdom teeth (Third		
Ovarian cysts			Speech difficulties			Molar) extraction		

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

	Y	N		Y	N		Y	N
Antibiotics			Latex			Sedatives		
Aspirin			Local anesthetics			Sleeping pills		
Barbiturates			Metals			Sulfa drugs		
Codeine			Penicillin			Other		
Iodine			Plastic					

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

	Y	N		Y	N		Y	N
Antibiotics			Diet pills			Sleeping pills		
Anticoagulants			Heart medication			Sulfa drugs		
Barbiturates			Insulin			Tranquilizers		
Blood thinners			Muscle relaxants			Other		
Codeine			Nerve pills					
Cortisone			Pain medication					

FAMILY DENTIST ______________________________
ADDRESS ______________________________
PHONE ______________________________

FAMILY PHYSICIAN ______________________________
ADDRESS ______________________________
PHONE ______________________________

Do you use more than two pillows to sleep or sleep in a recliner? Yes No
Have you lost or gained more than 10 pounds in the past year? Yes No

Do you have or have you had any disease, condition or problem not listed? Yes No
If yes, please list: ______________________________

Women: Are you pregnant or think you may be pregnant? Yes ___ Months
Nursing? Yes No

Women: Do you use birth control medications? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

______________________________ ______________________________
Patient/Guardian Signature Date

History Review

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Dentist Signature ______________________________ Date ____________________