

**Medical History Form**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

**For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your evaluation you will be asked some questions about your responses to this questionnaire and there may be 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. My last physical examination was on \_\_\_\_\_
- 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 my physician(s) is \_\_\_\_\_

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- 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? \_\_\_\_\_ Yes / No

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- 7. Are you taking any medicine(s) including non-prescription medicine? Yes / No  
If so, what medicine(s) are you taking? \_\_\_\_\_

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- 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. Are you ever short of breath after mild exercise or when lying down?----- Yes / No
    - 3. Do your ankles swell?----- Yes / No
    - 4. Do you have inborn heart defects?----- Yes / No
    - 5. Do you have a cardiac pacemaker?----- Yes / No
  - c. Allergy ----- Yes / No
  - d. Sinus Trouble----- Yes / No
  - e. Asthma or hayfever----- Yes / No
  - f. Fainting spells or seizures----- Yes / No
  - g. Persistent diarrhea or recent weight loss----- Yes / No
  - h. Hepatitis, jaundice, or liver disease----- Yes / No
  - i. Diabetes----- Yes / No
  - j. AIDS or HIV infection----- Yes / No
  - k. Thyroid problems----- Yes / No
  - l. Respiratory problems, emphysema, bronchitis, etc.-----**over**----- Yes / No

- m. Arthritis or painful swollen joints----- Yes / No
  - n. Stomach ulcer or hyperacidity----- Yes / No
  - o. Kidney trouble----- Yes / No
  - p. Tuberculosis----- Yes / No
  - q. Persistent swollen glands in neck----- Yes / No
  - r. Persistent cough or cough that produces blood----- Yes / No
  - s. Low blood sugar----- Yes / No
  - t. Sexually transmitted disease----- Yes / No
  - u. Epilepsy or other neurological disease----- Yes / No
  - v. Problems with mental health----- Yes / No
  - w. Cancer----- Yes / No
  - x. Problems of the immune system----- Yes / No
  - 9 .Do you have any history of eye disease, injury or surgery?----- Yes / No  
If so, explain\_\_\_\_\_
  - 10. Does anyone in your family have any eye disease?----- Yes / No  
If so, explain\_\_\_\_\_
  - 11. Have you had abnormal bleeding?----- Yes / No  
a. Have you ever required a blood transfusion?----- Yes / No
  - 12. Do you have any blood disorder such as anemia?----- Yes / No
  - 13. Have you ever had any treatment for a tumor or growth?----- Yes / No
  - 14. Are you allergic or have you had a reaction to:  
a. Local anesthetic----- Yes / No  
b. Penicillin or other antibiotic----- Yes / No  
c. Sulfa drugs----- Yes / No  
d. Barbiturates, sedatives, or sleeping pills----- Yes / No  
e. Asprin----- Yes / No  
f. Iodine----- Yes / No  
g. Codeine or other narcotics----- Yes / No  
h. Other----- Yes / No
  - 15. Have you had any serious trouble associated with any dental treatment? Yes / No  
If so, explain\_\_\_\_\_
  - 16. Do you have any disease, condition, or problem not listed above that you  
Think I should know about? If so, explain\_\_\_\_\_ Yes / No
  - 17. Are you wearing contact lenses?----- Yes / No
  - 18. Are you wearing removable dental appliances?----- Yes / No
- WOMEN**
- 19. Are you pregnant?----- Yes / No
  - 20. Do you have any problems associated with you menstrual period?----- Yes / No
  - 21. Are you nursing?----- Yes / No
  - 22. Are you taking birth control pills?----- Yes / No

Sinature\_\_\_\_\_ Date\_\_\_\_\_

Initialed\_\_\_\_\_ Date Reviewed\_\_\_\_\_ Initialed\_\_\_\_\_ Date Reviewed\_\_\_\_\_