



# Medical Health History

**Do you have, or have you had, any of the following?**

|  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Heart Problems.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain.....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure problem.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart valve problem.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking heart medication.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Problems.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Easy bruising.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent nosebleed.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal bleeding.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disease (anemia).....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever require a blood transfusion?.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergy Problems.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay fever.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin rashes.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking allergy medication.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Intestinal Problems.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight gain or loss.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Special diet.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney or bladder problems.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone or Joint Problems.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Back or neck pain.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| (e.g., total hip, pins, or implants)           |                          |                          |
| Fainting Spells, Seizures, or Epilepsy.....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent or severe headaches.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough or swollen glands.....        | <input type="checkbox"/> | <input type="checkbox"/> |
| Premedications required by physician.....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer (Tumor).....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes.....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinate more than 6 times a day.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Thirsty or mouth is dry much of the time.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of diabetes.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis or other respiratory disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink alcohol?.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how much?.....                          |                          |                          |
| Do you smoke or use smokeless tobacco?.....    | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how much?.....                          |                          |                          |
| Hepatitis, jaundice, or liver trouble.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes or other STD.....                       | <input type="checkbox"/> | <input type="checkbox"/> |

|  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| HIV positive/AIDS.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear contact lenses?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| History of head injury?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or other neurological disease?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| History of alcohol or drug abuse?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any disease, condition, or problem not listed<br>previously that you feel we should know about?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please describe:.....   |                          |                          |

**Are you allergic, or have you reacted adversely, to any of the following?**

|  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Local anesthetic (Novocaine).....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates, sedatives or sleeping pills..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin, Acetaminophen, or Ibuprofen.....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine, Demerol, or other narcotics.....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Reaction to metals.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex or rubber gloves.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Other.....                                     |                          |                          |

**During the past 12 months, have you taken any of the following:**

|   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Antibiotics or sulfa drugs.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Anticoagulants (i.e., Coumadin).....      | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure medicine.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Tranquilizers.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin, Orinase, or similar drug.....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Digitalis or drugs for heart trouble..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Nitroglycerin.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone (steroids).....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Natural remedies.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Nonprescription drug/supplements.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Other.....                                |                          |                          |

**Women**

|  |                          |                          |
|--|--------------------------|--------------------------|
| Are you taking oral contraceptives or other hormones?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant?.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, expected delivery date.....                         |                          |                          |
| Are you nursing?.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you reached menopause?.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, do you have any symptoms?.....                      |                          |                          |

**PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR ANY BALANCE THAT IS NOT PAID BY YOUR INSURANCE COMPANY.**

The above information is true and complete to the best of my knowledge. I agree to pay my co-payment at the time services are rendered. The Doctor is not responsible for completion of treatment if I consistently fail to keep scheduled appointments. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

**Patient Signature** (Parent's signature, if a minor) \_\_\_\_\_ **Date** \_\_\_\_\_

