

# MEDICAL HISTORY FORM

NAME: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

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 is \_\_\_\_\_  
\_\_\_\_\_
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
7. Are you taking any medication(s), including, weight loss medications and/or non-prescription medications? ..... Yes No  
If so, please list: \_\_\_\_\_
8. Are you allergic to any medications? \_\_\_\_\_
9. Do you have or have you had any of the following diseases or problems?
  - a. Damaged or artificial heart valves, including heart murmur or rheumatic heart disease? .....Yes No
  - b. Heart trouble (high blood pressure, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke) .....Yes No
  - c. Allergies or hay fever.....Yes No
  - d. Sinus trouble.....Yes No
  - e. Asthma.....Yes No
  - f. Fainting spells or seizures.....Yes No
  - g. Diabetes.....Yes No
  - h. Hepatitis, jaundice, or liver disease.....Yes No
  - i. AIDS or HIV infection.....Yes No
  - j. Thyroid problems.....Yes No
  - k. Respiratory problems, emphysema, bronchitis, etc.....Yes No
  - l. Arthritis or painful swollen joints.....Yes No
  - m. Kidney trouble.....Yes No
  - n. Tuberculosis.....Yes No
  - o. Low blood pressure.....Yes No
  - p. Sexually transmitted disease.....Yes No
  - q. Problems with mental health.....Yes No
  - r. Cancer.....Yes No
  - s. Artificial joints.....Yes No
10. Do you smoke? Yes No If so, how many packs per day? \_\_\_\_\_

WOMEN: Is there any possibility of pregnancy? \_\_\_\_\_ Are you nursing? \_\_\_\_\_ Are you taking birth control pills? \_\_\_\_\_

- |  |     |                             |
|--|-----|-----------------------------|
| Do your gums bleed while brushing or flossing?           | Yes | No                          |
| Are you teeth sensitive to hot or cold liquids?          | Yes | No                          |
| Do you feel pain to any of your teeth?                   | Yes | No                          |
| Do you have sores/lumps in or near your mouth?           | Yes | No                          |
| Have you had any head, neck, or jaw injuries?            | Yes | No                          |
| Have you ever experienced any of the following? (circle) |     |                             |
| Clicking   |     | Difficulty opening/ closing |
| Pain (ear, side of face, joint)                          |     | Difficulty chewing          |

- |  |     |    |
|--|-----|----|
| Do you have frequent headaches?                                      | Yes | No |
| Do you clench or grind you teeth?                                    | Yes | No |
| Do you bite your cheeks or lips frequently?                          | Yes | No |
| Have you had any orthodontic work?                                   | Yes | No |
| Have you had difficult extractions in the past?                      | Yes | No |
| Have you ever had instruction on the correct care of teeth and gums? | Yes | No |

Patient Signature: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_