MEDICAL HISTORY

PATIENT'S NAME _____ DATE _____

Please check any conditions which you have had in the past or have now. Parents and guardians, if you are completing this for your child, please indicate your child's health status.

CARDIOVASCULAR
- O heart failure
- O heart disease or attack
- O angina pectoris or chest pain
- O high blood pressure
- O heart murmur
- O rheumatic fever
- O congenital heart defect or lesion
- O artificial heart valve
- O heart pacemaker
- O heart surgery or transplant
- O other heart problems
- O stroke
- O aneurysm

HEMATOLOGIC
- O blood transfusion
- O anemia
- O hemophilia
- O leukemia
- O sickle cell (anemia) disease
- O tendency to bleed longer than normal

URINARY/ST
- O blood transfusion
- O anemia
- O hemophilia
- O leukemia
- O sickle cell (anemia) disease
- O tendency to bleed longer than normal

GASTROINTESTINAL
- O stomach or intestinal ulcers
- O gastritis
- O colitis
- O persistent diarrhea
- O hepatitis
- O liver disease
- O yellow jaundice
- O cirrhosis

RESPIRATORY
- O hay fever
- O sinus trouble
- O allergies or hives
- O asthma
- O chronic cough
- O emphysema
- O tuberculosis (TB)
- O breathing difficulties

NEURAL/SENSORY
- O eye pain
- O vision problems
- O glaucoma or cataract
- O earaches, ringing in ears
- O hearing loss
- O severe headaches
- O fainting or dizzy spells
- O epilepsy, seizures or convulsions
- O nervousness
- O psychiatric treatment

ENDOCRINE
- O diabetes
- O thyroid disease

DERMAL/MC/MS
- O skin rash
- O dark mole(s) - recent change in appearance
- O night sweats
- O sore muscles
- O stiff joints
- O arthritis
- O artificial joint
- O fever blister
- O mouth ulcers or canker sores
- O colored or discolored areas in mouth

OTHER CONDITIONS
- O frequent sore throats
- O enlarged lymph node or "gland"
- O use tobacco
- O use alcohol
- O drug addiction
- O tumor or cancer
- O x-ray or cobalt treatment
- O disease, problem or condition not listed _____

MEDICAL HISTORY p.2

Are you currently under the care of a physician? ○ yes ○ no

Are you taking (or supposed to be taking) any medicine, drugs, or pills of any kind? ○ yes ○ no
If yes, what kind and dose:

_____

_____

Have you taken Cortisone or other steroids in the past 12 months? ○ yes ○ no

Do you have reactions or allergies to drugs or medicines? ○ yes ○ no

Have you had a reaction to dental or general anesthetic? ○ yes ○ no

Have you ever had any operations or surgery? ○ yes ○ no
Describe the problem and any complications:

_____

_____

Have you ever been hospitalized? ○ yes ○ no

When you walk up stairs or take a walk, do you ever have to stop because of pain in you chest, shortness of breath, or because you are very tired? ○ yes ○ no

Do you ankles swell during the day? ○ yes ○ no

Do you sleep on two or more pillows? ○ yes ○ no

Have you unintentionally lost or gained more than 10 pounds in the past year? ○ yes ○ no

Are you on a special diet? ○ yes ○ no

Does your occupation bring you into contact with blood, blood products or needles? ○ yes ○ no

WOMEN:
Are you pregnant? ○ yes ○ no
Are you practicing birth control? ○ yes ○ no
Do you anticipate becoming pregnant in the upcoming year? ○ yes ○ no

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medicines change, I will inform the dentist at the next appointment without fail.

_____ _____

Date Signature of Patient, Parent or Guardian Dentist

OFFICE USE ONLY

Physician _____ Address _____

Phone No. _____ Last Appointment Date _____

For What? _____

Height _____ Weight _____ BP _____ Pulse _____ Rasp. _____ Temp. _____

Health Comments & Summary: ASA I II III IV

_____

_____

_____

_____