

# Medical History Form

FAMILY DENTAL

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

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_ Phone number \_\_\_\_\_

Please respond to the following questions regarding your medical health.

1) Date of last physical examination \_\_\_\_\_

2) Are you being treated for any medical condition?  
\_\_\_\_\_  
\_\_\_\_\_

3) Have you had a serious illness, operation or been hospitalized in the last 5 years?  
\_\_\_\_\_  
\_\_\_\_\_

4) Please list all prescription and non-prescription medications that you are taking:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) Are you allergic to or had a reaction to any of the following:

Local anesthetics	Yes ___	No ___
Penicillin or other antibiotics	Yes ___	No ___
Sulpha drugs	Yes ___	No ___
Sedatives	Yes ___	No ___
Aspirin	Yes ___	No ___
Codeine or other narcotics	Yes ___	No ___
Iodine	Yes ___	No ___
Other _____		

Do you have any other allergies? \_\_\_\_\_

6) Do you have any of the following conditions:

a. Diabetes	Yes ___	No ___
b. Insulin treated Diabetes	Yes ___	No ___
c. High blood pressure	Yes ___	No ___
d. Low blood pressure	Yes ___	No ___
e. Cardiovascular disease	Yes ___	No ___
f. Damaged heart valves/Rheumatic Heart Disease	Yes ___	No ___
g. Heart Murmur	Yes ___	No ___
h. Stroke	Yes ___	No ___
i. Shortness of Breath	Yes ___	No ___
j. Swollen ankles	Yes ___	No ___
k. Inborn heart defects	Yes ___	No ___
l. Cardiac pacemaker/Defibrillator	Yes ___	No ___
m. Heart attack	Yes ___	No ___
n. Angina/Chest Pain	Yes ___	No ___
o. Asthma	Yes ___	No ___
p. Fainting Spells	Yes ___	No ___
q. Seizures/Epilepsy	Yes ___	No ___
r. Hepatitis/Liver Disease	Yes ___	No ___
s. AIDS or HIV infection	Yes ___	No ___
t. Thyroid disease or problems	Yes ___	No ___
u. Emphysema/Bronchitis/COPD	Yes ___	No ___
v. Arthritis or painful joints	Yes ___	No ___
w. Stomach Ulcer/Reflux/Acidity	Yes ___	No ___
x. Crohn's or Colitis	Yes ___	No ___
y. Kidney Disease	Yes ___	No ___
z. Persistent Swollen Glands	Yes ___	No ___
aa. Mental Health Issues/Psychiatric Care	Yes ___	No ___

- bb. Anxiety Disorder/Panic Attacks Yes\_\_\_ No\_\_\_
- cc. Attention Deficit Disorder Yes\_\_\_ No\_\_\_
- dd. Depression Yes\_\_\_ No\_\_\_
- ee. Cancer/Radiation treatment Yes\_\_\_ No\_\_\_
- ff. Abnormal Bleeding Yes\_\_\_ No\_\_\_
- gg. Treatment of a tumor or growth Yes\_\_\_ No\_\_\_
- hh. Osteoporosis/Bisphosphonate medicine Yes\_\_\_ No\_\_\_

- 7) Do you smoke or use smokeless tobacco Yes\_\_\_ No\_\_\_
  - a) Are you a former tobacco user Yes\_\_\_ No\_\_\_
  - b) How many years have/did you used tobacco? \_\_\_\_\_
  - c) How much tobacco do/did you use per day? \_\_\_\_\_

- 8) Do you use/drink alcoholic beverages Yes\_\_\_ No\_\_\_
  - a) What type \_\_\_\_\_
  - b) How many times per week do you use alcoholic beverages? \_\_\_\_\_

- 9) Do you use illicit street drugs? Yes\_\_\_ No\_\_\_
  - a) What type \_\_\_\_\_

- 10) Do you wear contact lenses? Yes\_\_\_ No\_\_\_

- 11) Do you have pain/sounds in your TMJs? Yes\_\_\_ No\_\_\_

Women

- 11) Are you pregnant? Yes\_\_\_ No\_\_\_
- 12) Are you nursing? Yes\_\_\_ No\_\_\_
- 13) Are you taking birth control pills? Yes\_\_\_ No\_\_\_

I certify that I have read and understand the above questionnaire. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not withhold information regarding my medical health. I will not hold my surgeon/physician or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of the Patient \_\_\_\_\_

Signature of Guardian/Parent \_\_\_\_\_ Relationship \_\_\_\_\_

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**To be completed by Surgeon**

Medical Management Issues from questionnaire or oral interview

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\_\_\_\_\_

Date \_\_\_\_\_

Signature of Surgeon \_\_\_\_\_