MEDICAL HEALTH HISTORY PATIENT NAME: ____________________ Date__________

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: ____________________
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: ____________________

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4. Yes No Are you being treated by a physician now? For what? ____________________

Name of your physician: ____________________ Date of last Medical Exam: ____________________

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Diarrhea, constipation, blood in stools
14. Yes No Frequent vomiting, nausea
15. Yes No Difficulty urinating, blood in urine
16. Yes No Dizziness
17. Yes No Ringing in ears
18. Yes No Frequent Headaches
19. Yes No Fainting spells
20. Yes No Blurred Vision
21. Yes No Seizures
22. Yes No Excessive thirst
23. Yes No Frequent urination
24. Yes No Dry Mouth
25. Yes No Jaundice
26. Yes No Joint pain, stiffness
27. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

28. Yes No Heart disease
29. Yes No Heart attack, heart defects
30. Yes No Heart murmur
31. Yes No Rheumatic fever
32. Yes No Stroke, hardening of arteries
33. Yes No High Blood Pressure
34. Yes No TB, emphysema or other lung diseases
35. Yes No Hepatitis, A B C
36. Yes No Stomach problems, ulcers
37. Yes No Diabetes
38. Yes No Family History of diabetes, heart problems, cancer
39. Yes No HIV positive or AIDS-ARC
40. Yes No Tumors, Cancer
41. Yes No Arthritis, rheumatism
42. Yes No Eye disease
43. Yes No Skin disease
44. Yes No Anemia
45. Yes No VD (syphilis or gonorrhea)
46. Yes No Herpes
47. Yes No Kidney, bladder diseases
48. Yes No Thyroid, adrenal diseases
49. **ALLERGIES**: to drugs, food, medications, metals, jewelry, acrylics; **list the following allergies:**
____
____

D. DO YOU HAVE OR HAVE YOU HAD:

50. Yes No Surgeries ____________________
51. Yes No Blood Transfusions ____________________
52. Yes No Artificial Joint ____________________
53. Yes No Contact Lenses ____________________
54. Yes No Psychiatric Care ____________________
55. Yes No Radiation Treatments
56. Yes No Chemotherapy
57. Yes No Prosthetic heart valve
58. Yes No Pacemaker
59. Yes No **Women only**: Birth Control Pills
60. Yes No **Women only: Pregnant or nursing**

E. DO YOU TAKE:

61. Yes No Recreational drugs
62. Yes No Alcohol
63. Yes No Tobacco in any forms

Current Medications: ____________________
____
____

F. ALL PATIENTS:

64. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:
____

65. Yes No Have you ever been told by a physician or dentist that you need to pre-medicate prior to any dental treatment?

PATIENT'S ADDITIONAL COMMENTS: ____________________
____

Signature ____________________ BP ____/____ P ____ Date ___/___/____
Signature ____________________ BP ____/____ P ____ Date ___/___/____
Signature ____________________ BP ____/____ P ____ Date ___/___/____