PATIENT HEALTH RECORD AND MEDICAL HISTORY

(Please Print)

Name ______________________________ Date ____________
Last First MI

Address ______________________________ City ____________

State ________ Zip Code ____________ Home Phone ______________ Bus. Phone ____________

Patient's Cell Phone ______________ Emergency Contact Name & Ph. ______________

SS# ______________ Birthdate ______________ Occupation ______________

Place of Business ______________ City ______________ State ____________

Referring Dentist ______________ Reason for Referral ______________

Please circle correct answers:

Are you married, single, divorced, or widowed? (For insurance reasons)

Are you in good health? yes no If not, why? ______________

Do you smoke or use smokeless tobacco? yes no

Are you now or have you been under the care of a physician any time during the last five years? yes no

If Yes, reason: ______________

Are you currently taking any medication: yes no Please list: ______________

____

Are you taking or have you ever taken steroids (i.e. cortisone or birth control pills) or blood thinners (i.e. aspirin, coumadin)?

yes no If Yes, what? ______________

Are you sensitive or allergic to: Codeine Aspirin Novocain Penicillin or any other drug or medication?

yes no Please list: ______________

Physician's name: ______________ Date of last physical exam: ______________

Address: ______________ Telephone: ______________

Which of the following apply to you:

yes	no	
☐	☐	Need antibiotic premedication for dentistry
☐	☐	Mitral Valve Prolapse
☐	☐	Heart Murmur
☐	☐	Rheumatic fever or rheumatic heart disease
☐	☐	Heart problem
☐	☐	High blood pressure or hypertension
☐	☐	Low blood pressure
☐	☐	Shortness of breath or difficult in breathing
☐	☐	Pains in arms, legs or chest
☐	☐	Frequent headaches or migraine
☐	☐	Fainting, dizzy spells, epilepsy or convulsions
☐	☐	Tumor, cyst, cancer or other growths
☐	☐	Chemotherapy
☐	☐	Radiation therapy
☐	☐	Anemic or blood disorder
☐	☐	Diabetes
☐	☐	Do you have a persistent cough or cough up blood?
☐	☐	Stomach ulcers
☐	☐	Abnormal bleeding following extractions or surgery
☐	☐	Tuberculosis

yes	no	
☐	☐	Hepatitis, jaundice, or liver disease
☐	☐	AIDS
☐	☐	Positive HIV or HTLV test
☐	☐	Syphilis
☐	☐	Herpetic infection or cold sores
☐	☐	Sinus problems
☐	☐	Ear infections
☐	☐	Osteoporosis/Osteopenia
☐	☐	Glaucoma
☐	☐	Thyroid disease or insufficiency
☐	☐	Kidney disease
☐	☐	Malignant hyperthermia
☐	☐	Arthritis
☐	☐	Allergies to: ____________
☐	☐	Asthma
☐	☐	Nervous disorders
☐	☐	Major operation: ____________
☐	☐	Pregnant or nursing
☐	☐	Popping or clicking of the jaw
☐	☐	Periodontal treatment

Is there anything that you think is important for us to know? Please explain: ______________

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To the best of my knowledge the answers to the above questions are true and correct.

Date ____________ Patient Signature ______________ medical Hx reviewed by ______________

Date ______________