



Medical History

Health Information

I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No Are you in pain now?
If NO, explain _____
2. Yes / No Is your general health good?
If YES, explain _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
4. Yes / No Are you being treated by a physician now?
If YES, explain _____
Date of last medical exam? _____ Reason for exam _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain _____
Date of last exam _____ Name of treating dentist _____
6. Yes / No Has there been a change in your health within the last year?
If Yes, explain _____

II. Have you experienced any of the following? (Please circle Yes or No for each)

- | | | |
|----------------------------------|-----------------------------------|----------------------------------|
| Yes / No Chest pain | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night Sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |

III. Have you had or do you have any of the following? (Please circle Yes or No for each)

- | | | |
|--|--|-------------------------------------|
| Yes / No Heart Disease | Yes / No Cosmetic surgery | Yes / No Eating disorder |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid Disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of arteries | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| | | Yes / No Tuberculosis |

This information will not be released unless specifically authorized by patient.

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|-------------------|------------------|---------------------|--|
| Yes / No AIDS/HIV | Yes / No Anxiety | Yes / No Depression | Yes / No Treatment for emotional condition |
|-------------------|------------------|---------------------|--|

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

- | | | |
|--|-----------------------|------------------------|
| Yes / No Aspirin | Yes / No Valium | Yes / No Vicodin |
| Yes / No Darvon | Yes / No Demerol | Yes / No Percodan |
| Yes / No Codeine | Yes / No Penicillin | Yes / No Nitrous oxide |
| Yes / No Latex | Yes / No Food | Yes / No Metal |
| Yes / No Local anesthetic
(Novocain or Xylocaine) | Yes / No Erythromycin | |
| | Yes / No Tetracycline | |

Others: _____

V. Are you taking or have you taken any of the following in the last three months? (Please circle Yes or No for each)

- | | | |
|-------------------------------------|------------------------------|----------------------|
| Yes / No Bisphosphonate (Fosamax) | Yes / No Tobacco in any form | Yes / No Supplements |
| Yes / No Over-the-counter medicines | Yes / No Alcohol | Yes / No Aspirin |
| Yes / No Weight loss medications | Yes / No Recreational drugs | |
| Yes / No Corticosteroids | Yes / No Antibiotics | |

Please list all medications you are currently taking _____

VI. Women only (Please circle Yes or No for each)

- Yes / No Are you or could you be pregnant? If YES, what month? _____
- Yes / No Are you nursing?
- Yes / No Are you taking birth control pills?

VII. All patients (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, explain _____

Yes / No Have you ever been pre-medicated for dental treatment?
If YES, explain _____

Yes / No Have you ever taken Fen-Phen?
If YES, when _____

Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the doctor of any change in my health and/or medication. Further, I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature of Patient (Parent or Guardian)	_____ Date	_____ Signature of Dentist	_____ Date
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HIPAA Information:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct and indirect treatment by other health care providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company); the day-to-day health care operations of your practice. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care options, but that you are not required to agree to these requested restrictions. However, any use or disclose that occurred prior to the date I revoke this consent is not affected.

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

_____ Signature of Patient, Parent or Guardian	_____ Date
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