NEW Medical History Form 2017(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Name of your current physician ◯ Yes ◯ No If yes

Surgical Operations

Appendectomy ◯ Yes ◯ No	Back ◯ Yes ◯ No	Ear ◯ Yes ◯ No	Gallbladder ◯ Yes ◯ No
Heart ◯ Yes ◯ No	Hernia repair ◯ Yes ◯ No	Lung ◯ Yes ◯ No	Nasal ◯ Yes ◯ No
Thyroid ◯ Yes ◯ No	Tonsillectomy ◯ Yes ◯ No	Uvulectomy ◯ Yes ◯ No	Periodontal ◯ Yes ◯ No

Other: ◯ Yes ◯ No If yes

Family History

Has any member of your family (parent, sibling, or grandparent) had:

Cancer ◯ Yes ◯ No	Heart disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	High blood pressure ◯ Yes ◯ No
Stroke ◯ Yes ◯ No	Sleep disorder ◯ Yes ◯ No	Obesity ◯ Yes ◯ No	Thyroid disorder ◯ Yes ◯ No
Father snores ◯ Yes ◯ No	Mother snores ◯ Yes ◯ No	Father has sleep apnea ◯ Yes ◯ No	Mother has sleep apnea ◯ Yes ◯ No

Social History

Are you a tabbacco user of one of the fillowing:

Cigarettes ◯ Yes ◯ No	Pipe ◯ Yes ◯ No	Cigar ◯ Yes ◯ No	Snuff ◯ Yes ◯ No
Chew ◯ Yes ◯ No	Never used ◯ Yes ◯ No		

Currently smoking? How many packs a day? ◯ Yes ◯ No If yes

Quit smoking? When did you quit? ◯ Yes ◯ No If yes

Caffeine intake:

none ◯ Yes ◯ No	Coffee ◯ Yes ◯ No	Tea ◯ Yes ◯ No	Soda ◯ Yes ◯ No

Drink Caffeine? How much do you drink daily? ◯ Yes ◯ No If yes

Do you drink alcohol? # of drinks per week? ◯ Yes ◯ No If yes

Do you exercise? How often? ◯ Yes ◯ No If yes

Women: Are you...

☐ Pregnant	☐ Taking oral contraceptives	☐ Trying to get pregnant	☐ Nursing

Do you have any allergens to the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Antibiotics	☐ Sedatives	☐ Sleeping pills	☐ No known allergens

Other: ☐ If yes

Are you currently taking any medication? List: (NAME/DOSE/WHY? ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No	Hepatitis ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No
Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	Angina ◯ Yes ◯ No
Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No
High Cholesterol ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No
Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No
Tonsillitis ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No
Tumors or Growths ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Acid reflux ◯ Yes ◯ No	Atherosclerosis ◯ Yes ◯ No	Bleed Easily ◯ Yes ◯ No
Chronic fatigue ◯ Yes ◯ No	Chronic Pain ◯ Yes ◯ No	COPD ◯ Yes ◯ No	Coronary heart disease ◯ Yes ◯ No
Depression ◯ Yes ◯ No	Difficulty sleeping ◯ Yes ◯ No	Daytime Sleepiness ◯ Yes ◯ No	Fibromyalgia ◯ Yes ◯ No
Immune system disorder ◯ Yes ◯ No	Insomnia ◯ Yes ◯ No	Ischemic heart disease ◯ Yes ◯ No	Mood Disorder ◯ Yes ◯ No
Multiple sclerosis ◯ Yes ◯ No	Nasal allergies ◯ Yes ◯ No	Neuralgia ◯ Yes ◯ No	Osteoarthritis ◯ Yes ◯ No
Parkinson's disease ◯ Yes ◯ No	Prior Orthodontics ◯ Yes ◯ No	Rheumatic arthritis ◯ Yes ◯ No	Sleep apnea ◯ Yes ◯ No

If you marked "YES" please list below: Current Status and Date of Diagnosis ◯ Yes ◯ No If yes

Do you have any other Medical Condition not listed above? Please list below with Current status and Date of Diagnosis ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____