MEDICAL HEALTH HISTORY

PATIENT NAME: _____

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: _____

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 OR HAVE YOU HAD:

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Blood Thinner
9. Yes No Mitrovalve Prolapse
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Diabetes
14. Yes No Stroke
15. Yes No Anemia
16. Yes No Sleep apnea or chronic snoring
17. Yes No Heart disease
18. Yes No Heart attack, heart defects
19. Yes No Heart murmur
20. Yes No High Blood Pressure
21. Yes No Stroke, hardening of arteries
22. Yes No Stomach problems, ulcers
23. Yes No TB, emphysema or other lung diseases
24. Yes No Hepatitis, A B C
25. Yes No Allergies: **Circle all that apply: Latex, Penicillan, Sulfa, Codeine**
26. Yes No Dizziness
27. Yes No Ringing in ears
28. Yes No Frequent Headaches
29. Yes No Fainting spells
30. Yes No Blurred Vision
31. Yes No Seizures
32. Yes No Excessive thirst
33. Yes No Frequent urination
34. Yes No Dry Mouth
35. Yes No Jaundice
36. Yes No Rheumatic fever
37. Yes No Herpes
38. Yes No HIV positive or AIDS-ARC
39. Yes No Tumors, Cancer
40. Yes No Arthritis, rheumatism
41. Yes No Eye disease
42. Yes No Kidney, bladder diseases
43. Yes No Thyroid, adrenal diseases

C. DO YOU HAVE OR HAVE YOU HAD:

44. Yes No Surgeries _____
45. Yes No Blood Transfusions _____
46. Yes No Artificial Joint _____
47. Yes No Contact Lenses _____
48. Yes No Radiation Treatments _____
49. Yes No Chemotherapy _____
50. Yes No Prosthetic heart valve _____
51. Yes No Pacemaker _____
52. Yes No Psychiatric Care _____
53. **Women: Currently Pregnant or nursing**

D. DO YOU TAKE OR HAVE TAKEN:

54. Yes No Recreational drugs
55. Yes No Alcohol
56. Yes No Tobacco in any forms
57. Yes No Phen Phen diet Pills or any other diet pills
58. Yes No Bisphosphonates: Fosamax, Boniva, Prolia or Zometa

VITAMINS & MEDICATIONS: _____

E. ALL PATIENTS:

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

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