

MEDICAL HISTORY FORM

Name: _____ Date: _____
 Date of Birth: _____ Age: Sex: M / F Height: _____ Weight: _____
 Referring Doctor _____ Reason for Visit _____

For the following questions, circle Yes or No, whichever applies. Your answers will be kept confidential.

1. Are you in good health? Yes No
2. Has there been any change in your health in the past year? Yes No
3. My last physical exam was on _____ / _____ / _____
4. Are you now under the care of a physician? Yes No
 If so, for what condition? _____
5. Family Physician Name and Phone Number: _____
6. **Have you ever had any serious illness, operations or hospitalizations?** Yes No
If so, describe (including dates) _____
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? Yes No
8. **Do you have or have you had any of the following? (If "Yes" circle each condition that applies)**
 - a. Damaged heart valves, artificial valves or heart murmur Yes No
 - b. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, rheumatic heart disease, low blood pressure, or any other heart condition Yes No
 1. Chest pain upon exertion? Yes No
 2. Shortness of breath after mild exercise? Yes No
 3. Do your ankles swell? Yes No
 - c. Sinus trouble Yes No
 - d. Asthma or hay fever Yes No
 - e. Fainting spells or seizures Yes No
 - f. Diabetes Yes No
 - g. Hepatitis, jaundice or liver disease Yes No
 - h. Frequent or recurring mouth sores Yes No
 - i. Thyroid problems Yes No
 - j. Respiratory problems, emphysema, bronchitis, etc. Yes No
 - k. Arthritis or painful, swollen joints or glands Yes No
 - l. Osteoporosis Yes No
 - m. Stomach ulcer or hyperacidity Yes No
 - n. Kidney trouble Yes No
 - o. Tuberculosis Yes No
 - p. Persistent cough or cough that produces blood Yes No
 - q. Clicking or popping of jaw joint, difficulty opening mouth, grind or clench teeth, TMJ Yes No
 If so, describe treatment received and when _____
 - r. Epilepsy or neurological disorder Yes No
 - s. Cancer Yes No
 - t. Any disease, drug or transplant operation that has depressed your immune system Yes No
9. Have you had abnormal bleeding? Yes No
 - a. Have you ever required a blood transfusion? Yes No
10. Do you have any blood disorder such as anemia? Yes No
11. Have you ever had treatment for a tumor or growth? Yes No
12. Have you had radiation therapy to the head, neck or jaws? Yes No
13. Have you had any serious trouble associated with previous dental treatment? Yes No
 If so, explain: _____