

MEDICAL HISTORY

Please print in black or blue ink

Name _____ Mr. Mrs. Ms Date of Birth _____
Last First MI **Please circle**

Address _____
Street City State Zip code

Home phone # Cell phone # Bus. phone # Occupation

Emergency Contact Relationship Telephone

Physician's Name Address Telephone

Dentist's Name Address Telephone

If you are completing this form for another person, what is your name and your relationship to this person?

For the following questions, circle **yes** or **no**, whichever applies. Your answers are for our records only and will be considered **confidential**. Please note that you may be asked some questions about your responses and there may be additional questions concerning your health.

- 1. Has there been any change in your general health within the past year? yes no
- 2. Date of last physical exam _____
- 3. Are you now under the care of a physician? yes no
If so, what is the condition being treated? _____
- 4. Have you had any serious illness, operation or been hospitalized? yes no
If so, what was the illness or problem? _____
- 5. Are you taking any medicines(s), including non-prescription medicine? yes no
Please list name of medication(s), including dosage(s), if known _____

| 6. Do you have or have you had any of the following diseases or problems: | | | <u>Comments</u> |
|--|----|-----|-----------------|
| a. Damaged heart valves or artificial heart valves | no | yes | _____ |
| b. Rheumatic fever or rheumatic heart disease | no | yes | _____ |
| c. Congenital heart problems | no | yes | _____ |
| d. Heart murmur or mitral valve prolapse | no | yes | _____ |
| e. Cardiovascular disease (heart trouble, heart attack, angina, , stroke, high blood pressure, coronary artery disease | no | yes | _____ |
| f. Do you have a cardiac pacemaker? | no | yes | _____ |
| g. Allergy, hives, skin rash, or hay fever | no | yes | _____ |
| h. Asthma | no | yes | _____ |
| i. Fainting spells or episodes of unconsciousness | no | yes | _____ |
| j. Epilepsy or other neurological disorders | no | yes | _____ |
| k. Diabetes | no | yes | _____ |
| If so, what type? _____ | | | |
| Is there a history of diabetes in your family? | no | yes | _____ |
| If so, what is their relationship to you? _____ | | | |
| l. Hepatitis or liver disorder | no | yes | _____ |

| | | | |
|--|----|-----|-------|
| m. Persistent diarrhea or recent weight loss | no | yes | _____ |
| n. HIV positive, AIDS, or other immune system problems | no | yes | _____ |
| o. Thyroid problems. | no | yes | _____ |
| p. Respiratory problems, emphysema, bronchitis, etc | no | yes | _____ |
| q. Tuberculosis | no | yes | _____ |
| r. Persistent cough or cough that produces blood | no | yes | _____ |
| s. Arthritis, painful joints or osteoporosis | no | yes | _____ |
| t. Joint replacement | no | yes | _____ |
| u. Stomach ulcers, esophageal reflux, inflammatory bowel disorder. | no | yes | _____ |
| v. Kidney disease or renal dialysis treatment | no | yes | _____ |
| w. Persistent swollen glands, mononucleosis, chronic fatigue syndrome | no | yes | _____ |
| x. Low blood pressure | no | yes | _____ |
| y. Sexually transmitted disease | no | yes | _____ |
| z. mental health disorders (anxiety, depression, ADD, etc.) | no | yes | _____ |
| aa. History of alcohol or drug abuse | no | yes | _____ |
| bb. Eating disorders | no | yes | _____ |
| cc. Cancer | no | yes | _____ |
| dd. Radiation therapy or chemotherapy | no | yes | _____ |
| ee. Treatment for a tumor or growth | no | yes | _____ |
| ff. Blood disorder (such as anemia, hemophilia, leukemia) | no | yes | _____ |
| If so, how is it treated? _____ | | | |
| gg. Abnormal bleeding or bruising | no | yes | _____ |
| hh. Previous blood transfusions | no | yes | _____ |
| ii. Recurrent cold sores or fever blisters | no | yes | _____ |
| 7. Do you use any tobacco products ? | no | yes | _____ |
| 8. Have you ever taken appetite suppressants? (i.e. Fenphen, Redux) | no | yes | _____ |
| 9. Have you been treated with cortisone or steroids in the last 2 years? | no | yes | _____ |
| 10. Do you take any nutritional or herbal supplements? | no | yes | _____ |
| 11. Are you allergic or have you ever reacted to: | | | |
| a. Local anesthetics | no | yes | _____ |
| b. Penicillin or other antibiotics | no | yes | _____ |
| c. Sulfa drugs | no | yes | _____ |
| d. Aspirin or other medicines for pain | no | yes | _____ |
| e. Iodine or shellfish products | no | yes | _____ |
| f. Latex products | no | yes | _____ |
| g. Dyes | no | yes | _____ |
| h. Bisulfites or sulfite agents | no | yes | _____ |
| i. Any drugs, food, or other substance not listed above | no | yes | _____ |
| 12. Do you have any disease, condition, or problem not listed above that you think we should know about? | no | yes | _____ |
| If yes, please explain _____ | | | |

Female Patients Only

| | | | |
|--|----|-----|-------|
| 13. Are you pregnant? (If yes, trimester _____) | no | yes | _____ |
| 14. Are you nursing? | no | yes | _____ |
| 15. Do you have any problems associated with your menstrual period ? | no | yes | _____ |
| 16. Do you take oral contraceptives or other hormonal therapy? | no | yes | _____ |

DENTAL HISTORY

1. Date of last dental exam in a dental office and what was done? _____

2. Date of last dental x-rays and type, if known _____

| 3. Have you ever had any of the following: | no | yes | <u>Comments</u> |
|--|-------|-----|-----------------|
| a. orthodontic treatment | no | yes | _____ |
| b. periodontal treatment | no | yes | _____ |
| c. oral surgery or extractions | no | yes | _____ |
| d. endodontic treatment or root canals | no | yes | _____ |
| e. prosthodontic treatment (crowns/bridgework) | no | yes | _____ |
| f. dental implants | no | yes | _____ |
| g. facial trauma | no | yes | _____ |
| h. treatment for TMJ problems | no | yes | _____ |
| 4. Have you had any serious trouble associated with any previous dental treatment? | no | yes | _____ |
| If yes, please explain _____ | | | |
| 5. Are you ever anxious or uncomfortable about having dental treatment? | no | yes | _____ |
| 6. Are you wearing any removable dental appliances? | no | yes | _____ |
| 7. Do you frequently have a dry mouth? | no | yes | _____ |
| 8. Do you currently have any dental or mouth pain ? | no | yes | _____ |
| If yes, please explain _____ | | | |
| 9. Do your gums bleed when you brush or floss? | no | yes | _____ |
| 10. Do you have sensitive teeth? | no | yes | _____ |
| 11. Do you ever have canker sores or cold sores? | no | yes | _____ |
| 12. Do you have problems with food getting trapped between your teeth? | no | yes | _____ |
| 13. Is it difficult for you to open your mouth wide? | no | yes | _____ |
| 14. Does your jaw click or have pain upon opening? | no | yes | _____ |
| 15. Do you clench or grind your teeth? | no | yes | _____ |
| 16. Do you wear a nightguard or a retainer? | no | yes | _____ |
| 17. Do you gag easily? | no | yes | _____ |
| 18. Type of toothbrush used – soft, medium, hard, electric | _____ | | |
| 19. How often do you: | | | |
| a. brush your teeth _____ | | | |
| b. use dental floss _____ | | | |

To the best of my knowledge, the above medical history is accurate and has been completed by me.

Patient/parent/guardian signature

Date

Student signature

Blood Pressure

Pulse

Respiration

ASA Classification

Instructor's Initials

Medical Consult required? No Yes Reason _____