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MEDICAL FORM

Last name:	First:	Middle

Birthdate:	Height:	Weight:	Sex: Male ☐ Female ☐

Physician's name:	Address:

Telephone no.:	Last physical examination was on:

Reason for today's visit____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? .... Yes No
2. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ____________________________
3. Have you had a serious illness or operation? .... Yes No
   If so, what was the illness or operation? ____________________________
4. Do you have now or have you had any of the following diseases, symptoms, or problems?
   a. Damaged or artificial heart valves .... Yes No
   b. Heart murmur or rheumatic fever .... Yes No
   c. Congenital heart lesions .... Yes No
   d. Cardiovascular disease (heart trouble, heart attack, enlarged heart, high blood pressure, arteriosclerosis, stroke) .... Yes No
      1. Do you have chest pain on exertion? .... Yes No
      2. Are you short of breath after mild exercise? .... Yes No
      3. Do your ankles swell? .... Yes No
      4. Do you get short of breath when you lie down or do you need extra pillows when you sleep? .... Yes No
      5. Do you have a heart pacemaker? .... Yes No
   e. Allergy .... Yes No
   f. Sinus trouble .... Yes No
   g. Asthma or hay fever .... Yes No
   h. Hives or skin rash .... Yes No
   i. Fainting spells or seizures (epilepsy) .... Yes No
   j. Diabetes .... Yes No
      1. Do you have to urinate (pass water) more than six times a day? .... Yes No
      2. Are you thirsty much of the time? .... Yes No
      3. Does your mouth frequently become dry? .... Yes No
   k. Hepatitis, jaundice, or liver disease .... Yes No
   l. Arthritis or rheumatism .... Yes No
   m. Ulcers .... Yes No
   n. Kidney trouble .... Yes No
   o. Tuberculosis .... Yes No
   p. Do you have a persistent cough or cough up blood? .... Yes No
   q. Thyroid or endocrine (glandular) disease .... Yes No
   r. Venereal disease .... Yes No
   s. Cancer .... Yes No
   t. Psychiatric problems .... Yes No

u. AIDS, HIV or other immunosuppressive diseases .... Yes No
v. Prosthetic joint (artificial hip or knee) .... Yes No
w. Transplanted organ .... Yes No
x. Drug or substance abuse .... Yes No
Other (please describe) ____________________

5. Have you had any abnormal bleeding associated with previous dental extractions, surgery, or trauma? .... Yes No
   a. Do you bruise easily? .... Yes No
   b. Have ever required a blood transfusion? .... Yes No
      If so, explain the circumstances ____________________
6. Do you have any blood disorder? .... Yes No
   If so, please explain ____________________
7. Have you had any surgery, radiation, or treatment for a tumor or growth in your head or neck? .... Yes No
   If so, please describe the condition. ____________________
8. Are you taking any of the following medications?
   a. Antibiotics .... Yes No
   b. Anticoagulants .... Yes No
   c. Medicine for high blood pressure .... Yes No
   d. Steroids .... Yes No
   e. Tranquilizers .... Yes No
   f. Antihistamines .... Yes No
   g. Aspirin, tylenol, or other analgesics .... Yes No
   h. Insulin or orinase .... Yes No
   i. Digitalis or other medication for heart trouble .... Yes No
   j. Nitroglycerine .... Yes No
   k. Ventolin or other bronchodilators .... Yes No
   l. Oral contraceptives .... Yes No
   m. Any other medications (including herbal supplements) ____________________
9. Are you allergic or have you reacted adversely to any of the following?
   a. Penicillin or other antibiotics .... Yes No
   b. Local anesthetics .... Yes No
   c. Codeine or other narcotics .... Yes No
   d. Aspirin .... Yes No
   e. Barbiturates, sedatives, or valium .... Yes No
   f. Other ____________________
10. Are there any diseases, conditions, or problems not listed that I should know about?
    Please explain. ____________________
11. Are you pregnant? .... Yes No
12. Are you nursing? .... Yes No
13. Have you had any problems associated with any previous dental treatment?
    Please explain ____________________
14. Please explain any problems you are having with your mouth, teeth, or gums. ____________________
    ____

Medications:

Please list all medication you are taking with or without presciptions:

I acknowledge that the above questions have been answered truthfully and to the best of my knowledge. I will not hold the dentist or any member of the staff responsible for any omissions or errors made on my part in completing this form.

I certify that I have read, understand, and accept the provisions stated above.

Signature of Patient or Representative/Guardian:		Date: