

Medical History Form

Name _____ Date _____ Gender M F O

Email Address _____ Pharmacy Name/Address _____

Date of Birth _____ Height _____ Weight _____ Spouse _____

Address _____

Home # _____ Cell # _____ Guarantor _____ DOB _____

Employer _____ Insurance Co _____ SSN _____

Dentist Name _____ Physician Name _____

Please respond to the following questions regarding your medical health:

1) Date of last physical examination _____

2) Are you being treated for any medical condition? _____

3) Have you had a serious illness, operation or been hospitalized? _____

4) Please list all prescription and non-prescription medications that you are taking (dose and time of day):

5) Are you allergic to or had a reaction to any of the following:

Local Anesthetics	Yes	No
Penicillin Antibiotics	Yes	No
Sulpha Drugs	Yes	No
Sedatives	Yes	No
Aspirin/NSAIDS	Yes	No
Codeine or other Narcotics	Yes	No
Iodine	Yes	No
Do you have any other allergies? _____		

6) Do you have any of the following:

a. Diabetes	Yes	No
b. Insulin treated diabetes	Yes	No
c. High blood pressure	Yes	No
d. Low blood pressure	Yes	No
e. Cardiovascular disease	Yes	No
f. Damaged heart valves/rheumatic heart disease	Yes	No
g. Heart murmur	Yes	No
h. Stroke	Yes	No
i. Shortness of breath	Yes	No
j. Swollen ankles	Yes	No
k. Inborn heart defects	Yes	No
l. Cardiac pacemaker/defibrillator	Yes	No
m. Heart attack	Yes	No
n. Angina/chest pain	Yes	No
o. Asthma	Yes	No
p. Fainting spells	Yes	No
q. Seizures/epilepsy	Yes	No
r. Hepatitis/liver disease	Yes	No

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|-------------------------------------------|-----|----|
| s. AIDS or HIV infection | Yes | No |
| t. Thyroid disease or problems | Yes | No |
| u. Emphysema/bronchitis/COPD | Yes | No |
| v. Arthritis or painful joints | Yes | No |
| w. Stomach ulcer/reflux/acidity | Yes | No |
| x. Crohn's or colitis | Yes | No |
| y. Kidney disease | Yes | No |
| z. Persistent swollen glands | Yes | No |
| aa. Mental health issues/psychiatric care | Yes | No |
| bb. Anxiety disorder/panic attacks | Yes | No |
| cc. Attention deficit disorder | Yes | No |
| dd. Depression | Yes | No |
| ee. Cancer/radiation treatment | Yes | No |
| ff. Abnormal bleeding | Yes | No |
| gg. Treatment of a tumor or growth | Yes | No |
| hh. Osteoporosis/bisphosphonate medicine | Yes | No |
| ii. Sleep apnea | Yes | No |

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| 7) Do you smoke or use smokeless tobacco? | Yes | No |
| a) Are you a former tobacco user? | Yes | No |
| b) How many years have/did you use tobacco? _____ | | |
| c) How much tobacco do/did you use per day? _____ | | |

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|------------------------------------------------------------------|-----|----|
| 8) Do you use/drink alcoholic beverages? | Yes | No |
| a) What type _____ | | |
| b) How many times per week do you use alcoholic beverages? _____ | | |

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|-----------------------------------------|-----|----|
| 9) Do you use any illicit street drugs? | Yes | No |
| a) What type _____ | | |

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|---------------------------------|-----|----|
| 10) Do you wear contact lenses? | Yes | No |
|---------------------------------|-----|----|

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|---------------------------------------------------------------|-----|----|
| 11) Do you have pain/sounds in your Temporomandibular joints? | Yes | No |
|---------------------------------------------------------------|-----|----|

Women

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| 12) Are you pregnant? | Yes | No |
|-----------------------|-----|----|

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|----------------------|-----|----|
| 13) Are you nursing? | Yes | No |
|----------------------|-----|----|

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|-----------------------------------------|-----|----|
| 14) Are you taking birth control pills? | Yes | No |
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I certify that I have read and understand the above questionnaire. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not withhold information regarding my medical health. I will not hold my surgeon/physician or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of the Patient _____

Signature of Guardian/Parent _____ Relationship _____

To be completed by Surgeon

Medical Management issues from questionnaire or oral interview

Date _____ Signature of Surgeon _____

Date _____ Signature of Surgeon _____

Date _____ Signature of Surgeon _____