2019 Medical Hx Form

Patient Name: Birth Date: Date Created:

Questions

Question	Answer	
Are you new to our practice? If yes, who referred you?	Yes / No	If yes
Are you under a physician's care now? If yes, who is your primary care physician?	Yes / No	If yes
Have you ever been hospitalized or had a major operation? If yes, what? And when?	Yes / No	If yes
Have you ever had a serious head or neck injury? If yes, what happened? When?	Yes / No	If yes
Are you taking any medications, pills or drugs? If yes, please list.	Yes / No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes / No	If yes
Do you use controlled substances, such as narcotics? If yes, please list drug and reason for use.	Yes / No	If yes
Have you ever had an artificial joint replacement (knee, hip, etc.)? If yes, when was it done? Any complications?	Yes / No	If yes
Have you ever been told to take a premedication prior to dental treatment?	Yes / No	If yes
If you answered yes to the question above, please list prescribing physician's name.	Yes / No	If yes

Tobacco usage:

Cigarettes/e-cigarettes Yes No	Smokeless tobacco/chew Yes No	Interested in quitting? Yes No	Quit date ________ Yes No

Women only:

Are you pregnant? Yes No	Nursing? Yes No	Taking oral contraceptives? Yes No	Trying to get pregnant? Yes No

Allergies?

Acrylic Yes No	Aspirin Yes No	Codeine Yes No	Latex Yes No
Local anesthetics Yes No	Metals Yes No	Penicillin/Amoxicillin Yes No	Sulfa drugs Yes No
Other __________ Yes No			

Do you have, or have you had, any of the following:

Arthritis/Gout

Osteoarthritis Yes No	Rheumatoid arthritis/rheumatism Yes No	Other __________ Yes No	

Autoimmune disorders

Ehlers-Danlos syndrome Yes No	Fibromyalgia Yes No	Lupus Yes No	Multiple sclerosis Yes No
Psoriasis Yes No	Other __________ Yes No		

Blood Disorders

Anemia Yes No	Blood transfusion Yes No	Excessive bleeding Yes No	Hemophilia Yes No
Leukemia Yes No	Sickle cell disease Yes No	Other __________ Yes No	

Bone, Tendon and Ligament Disorders

Osteoporosis Yes No	TMJ/pain in jaw joint Yes No	Other __________ Yes No	

Do you have, or have you had, any of the following:

Breathing/Lung Disorders

Asthma ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	COPD ◯ Yes ◯ No	Easily winded ◯ Yes ◯ No
Persistent cough ◯ Yes ◯ No	Sleep apnea (CPAP/bipap use) ◯ Yes ◯ No	Snoring ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Other ________ ◯ Yes ◯ No			

Cancer

Type and date of occurence ________ ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Radiation ◯ Yes ◯ No	Other ________ ◯ Yes ◯ No

Diabetes and Thyroid Disorders

Type I diabetes ◯ Yes ◯ No	Type II diabetes ◯ Yes ◯ No	Most recent A1c: ________ ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No
Hyperthyroidism ◯ Yes ◯ No	Hypothyroidism ◯ Yes ◯ No	Parathyroidism ◯ Yes ◯ No	Other ________ ◯ Yes ◯ No

Eye, Ear, Nose and Throat Disorders

Cataracts ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Seasonal allergies ◯ Yes ◯ No	Sinus troubles ◯ Yes ◯ No
Tonsilectomy ◯ Yes ◯ No	Tubes in ears ◯ Yes ◯ No	Other ________ ◯ Yes ◯ No	

Head and Brain Disorders

Alzheimer's disease ◯ Yes ◯ No	Epilepsy/seizures ◯ Yes ◯ No	Fainting/dizziness ◯ Yes ◯ No	Headaches/migraines ◯ Yes ◯ No
Other ________ ◯ Yes ◯ No			

Heart Trouble/Diseases

Angina/chest pain ◯ Yes ◯ No	Artificial heart valve ◯ Yes ◯ No	Congenital heart defect ◯ Yes ◯ No	Endocarditis ◯ Yes ◯ No
Heart attack ◯ Yes ◯ No	Heart murmur ◯ Yes ◯ No	High blood pressure ◯ Yes ◯ No	High cholesterol ◯ Yes ◯ No
Irregular heart beat ◯ Yes ◯ No	Pacemaker ◯ Yes ◯ No	Rheumatic fever ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Other ________ ◯ Yes ◯ No			

Intestinal and Stomach Disorders

Acid reflux/GERD ◯ Yes ◯ No	Celiacs disease/gluten intolerance ◯ Yes ◯ No	Other ________ ◯ Yes ◯ No	

Kidney and Liver Diseases

Cirrhosis ◯ Yes ◯ No	Dialysis ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Hepatitis B/C ◯ Yes ◯ No
Other ________ ◯ Yes ◯ No			

Mental Health Disorders

Anxiety ◯ Yes ◯ No	ADHD/ADD ◯ Yes ◯ No	Bipolar ◯ Yes ◯ No	Depression ◯ Yes ◯ No
Panic attacks ◯ Yes ◯ No	PTSD ◯ Yes ◯ No	Schizophrenia ◯ Yes ◯ No	Other ________ ◯ Yes ◯ No

Viral

AIDS/HIV ◯ Yes ◯ No	Cold sores/fever blisters ◯ Yes ◯ No	Shingles ◯ Yes ◯ No	Other ________ ◯ Yes ◯ No

Have you ever had any other serious illnesses or diseases not listed above? If yes, please explain. ◯ Yes ◯ No If yes

Blood pressure (OFFICE USE ONLY): ◯ Yes ◯ No If yes

Signature of Patient, Parent or Guardian:

X

Date:__________