1. Please make sure it is fully completed.

2. Comment on all positive entries.

3. Review at the beginning of each appointment and verbally ask if there are any changes.

4. If all entries are negative, sign and have a staff dentist counter sign at their convenience.

5. If positive entries exist, sign and have a staff dentist counter sign before starting treatment.

6. The “Medical History Form” should be formally updated twelve months from the last treatment episode.
DENTAL CLINIC MEDICAL HISTORY

NAME: ______________________________________________________________ DATE: ____________________

Last First MI
Social Security: _____/_____/_______ Height: ________ Weight: ________ Birth Date: _______________________

Occupation: ____________________________ Phone: ____________________ Work Phone: ___________________

In 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. Has there been any change in your general health within the past year? ………………………….YES NO

3. Are you now under the care of a physician?……………………………………………………………..YES NO

If so, what is the condition being treated?________________________________________________________

4. Your physician’s name, address, & telephone number are:__________________________________________

_____________________________________________________________________________________________________

___________________________________________________________________________________

5. Have you had any serious illness or operations?…………………………………………………………YES NO

If so, what was the illness or operation?__________________________________________________________

6. Do you have, or have you had any of the following diseases or problems:

   a. Damaged heart valves or artificial heart valves, including murmur…………….………………...YES NO

   b. Congenital heart lesions…………………………………………………………….…………………YES NO

   c. Cardiovascular disease, heart trouble, heart attack, coronary insufficiency,

       1. Coronary occlusion, high blood pressure, arteriosclerosis, stress………………………YES NO

       2. Are you ever 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?………………………………………………...YES NO

       5. Do you require extra pillows when you sleep?………………………………………………….YES NO

       6. Do you have a cardiac pacemaker?……………………………………………………………...YES NO

   d. Allergies………………………………………………………………………………………………...YES NO

   e. Sinus trouble…………………………………………………………………………………………...YES NO

   f. Asthma or hay fever…………………………………………………………………………………...YES NO

   g. Hives or a skin rash…………………………………………………………………………………………...YES NO

   h. Fainting spells, seizures or epilepsy…………………………………………………………………..YES NO

   i. 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

   j. Hepatitis, jaundice or liver disease…………………………………………………………………...YES NO

   k. Arthritis or inflammatory rheumatism (painful swollen joints)……………………………………..YES NO

   l. Stomach ulcers…………………………………………………………………………………………...YES NO

   m. Kidney trouble…………………………………………………………………………………………...YES NO

   n. Tuberculosis………………………………………………………………………………………………...YES NO

   o. Do you have a persistent cough, or cough up blood………………………………………………..YES NO

   p. Low blood pressure……………………………………………………………………………………...YES NO

   q. Sexually Transmitted Diseases (Gonorrhea, Syphilis, Genital Herpes)………………………….YES NO

   r. Psychiatric problems……………………………………………………………………………………...YES NO

   s. Cancer or Leukemia……………………………………………………………………………………...YES NO

   t. AIDS or other immunosuppressive disorders………………………………………………………..YES NO

   u. Other…………………………………………………………………………………………………...YES NO

7. Have you had abnormal bleeding associated with previous extraction’s, surgery, or trauma?……….YES NO

   a. Do you bruise easily?………………………………………………………………………………....YES NO

   b. Have you ever required a blood transfusion?…………………………………………………..YES NO

     If so, explain the circumstances______________________________________________________

8. Do you have any blood disorders, such as anemia, sickle cell disease?…………………………………YES NO

9. Do you consume alcohol or smoke cigarettes/smokeless tobacco on a daily basis?…………………..YES NO

10. Have you ever used drugs; cocaine, marijuana, prescription drugs..et. for recreational purposes?... YES NO
11. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck. YES NO

12. Are you taking any of the following:
   a. Antibiotics or sulfa drugs………………………………………………………………………………………... YES NO
   b. Anticoagulants (blood thinners)…………………………………………………………………………………… YES NO
   c. Medicine for high blood pressure……………………………………………………………………………….. YES NO
   d. Cortisone (steroids)………………………………………………………………………………………………. YES NO
   e. Tranquilizers……………………………………………………………………………………………………... YES NO
   f. Antihistamines……………………………………………………………………………………………………. YES NO
   g. Aspirin………………………………………………………………………………………………………….... YES NO
   h. Insulin, Tolbutanide (Orinase) or similar drugs……………………………………………………………….. YES NO
   i. Digitalis or drugs for heart trouble……………………………………………………………………………... YES NO
   j. Nitroglycerin……………………………………………………………………………………………………… YES NO
   k. Oral contraceptive or other hormonal therapy………………………………………………………………... YES NO
   l. Other……………………………………………………………………………………………………………… YES NO

13. Are you allergic or have reacted adversely to:
   a. Local anesthetic………………………………………………………………………………………………….. YES NO
   b. Penicillin or other antibiotics…………………………………………………………………………………… YES NO
   c. Sulfa drugs……………………………………………………………………………………………………….. YES NO
   d. Barbiturates, sedatives, or sleeping pills……………………………………………………………………….. YES NO
   e. Aspirin……………………………………………………………………………………………………………. YES NO
   f. Iodine………………………………………………………………………………………………………….... YES NO
   g. Codeine or other narcotics………………………………………………………………………………………. YES NO
   h. Other……………………………………………………………………………………………………………. YES NO

14. Have you had any serious trouble associated with any previous dental treatment?……………………………… YES NO

15. Do you have any disease, condition or problem listed above that you think I should know about?…………….. YES NO
    If so, explain:________________________________________________________________________________________

WOMAN

16. Are you pregnant?………………………………………………………………………………………………………. YES NO

17. Do you have any problems associated with your menstrual period?……………………………………………… YES NO

18. Are you nursing?……………………………………………………………………………………………………….. YES NO

CHIEF DENTAL COMPLAINT: PLEASE LIST ________________________________________________________________

ARE YOU CURRENTLY HAVING PROBLEMS WITH DENTAL PAIN OR PAIN MANAGEMENT………………..YES NO
    IF SO – HOW SEVERE IS IT IN A SCALE OF 1-5 WITH 5 BEING WORST…………………………………… 1     2     3     4     5

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

MEDICAL UPDATES
I have read my Medical History dated__________ and confirm that it adequately states past and present conditions.

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<tr>
<th>DATE</th>
<th>EXCEPTIONS</th>
<th>PATIENT SIGNATURE</th>
<th>REVIEWED BY</th>
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