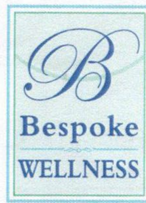

MEDICAL HISTORY

PATIENT'S NAME ______________________________ DATE ____________

Please check the box for any condition which you have had in the past or have now. (Parents or Guardian) If you are completing this form for your child, please indicate your child's health status by checking the appropriate box.

(1) CARDIOVASCULAR

- Heart Failure ❑
- Heart Disease or Attack ❑
- Angina Pectoris or Chest Pain ❑
- High Blood Pressure ❑
- Heart Murmur ❑
- Mitral Valve Prolapse ❑
- Rheumatic Fever ❑
- Congenital Heart Defect or Lesion ❑
- Artificial Heart Valve ❑
- Arrhythmias ❑
- Heart Pacemaker or Defibrillator ❑
- Heart Surgery or Transplant ❑
- Other Heart Problems ❑
- Stroke ❑
- Aneurysm ❑

(2) HEMATOLOGIC

- Blood Transfusion ❑
- Anemia ❑
- Hemophilia ❑
- Leukemia ❑
- Sickle Cell (Anemia) Disease ❑
- Tendency to Bleed Longer than Normal ❑

(3) NEURAL/SENSORY

- Eye Pain ❑
- Vision Problems ❑
- Glaucoma ❑
- Earaches, Ringing in Ears ❑
- Hearing Loss ❑
- Severe Headaches ❑
- Fainting or Dizzy Spells ❑
- Epilepsy, Seizures or Convulsions ❑
- Nervousness ❑
- Psychiatric Treatment ❑

(4) GASTROINTESTINAL

- Stomach/Intestinal Ulcers ❑
- Gastritis ❑
- Colitis ❑
- Persistent Diarrhea ❑
- Hepatitis ❑
- Liver Disease ❑
- Yellow Jaundice ❑
- Cirrhosis ❑

(5) RESPIRATORY

- Hay Fever ❑
- Sinus Trouble ❑
- Allergies or Hives ❑
- Asthma ❑
- Chronic Cough ❑
- Emphysema ❑
- Tuberculosis ❑
- Breathing Difficulties ❑

(6) DERMAL/MC/MS

- Allergy to Latex (Rubber) ❑
- Skin Rash ❑
- Dark Mole(s) (Recent changes in appearance) ❑
- Night Sweats ❑
- Sore Muscles ❑
- Stiff Joints ❑
- Arthritis ❑
- Artificial Joint ❑
- Fever Blister; Cold Sore ❑
- Mouth Ulcers or Canker Sores ❑
- Colored or Discolored Areas in Mouth ❑

(7) ENDOCRINE

- Diabetes ❑
- Thyroid Disease ❑

(8) URINARY/ST

- Urinate Frequently ❑
- Kidney, Bladder Problem ❑
- Sexually Transmitted Disease (Syphilis, Gonorrhea, Chlamydia or Genital Herpes) ❑
- HIV Positive ❑

(9) OTHER CONDITIONS

- Frequent Sore Throats ❑
- Enlarged Lymph Node or "Gland" ❑
- Use Tobacco ❑
- Use Alcohol ❑
- Drug or Alcohol Addition (Recovering or Current) ❑
- Tumor or Cancer ❑
- X-ray or Cobalt Treatment ❑
- Chemotherapy ❑
- Disease, Problem or Condition Not Listed ❑

If yes, list

____

____

____

10. Are you currently under the care of a physician? ❑ yes ❑ no
Physician Name ______________________ Address ______________________
Phone No. ________________ Last Appointment Date ______________________
For What? ____

11. Are you taking (or supposed to be taking) any medicine, drugs, or pills of any kind? ❑ yes ❑ no
If yes, what kind and dose
____
____
____

12. Have you taken Cortisone or other steroids in the past 12 months? ❑ yes ❑ no
13. Do you have reactions or allergies to drugs or medicines? ❑ yes ❑ no
14. Have you had a reaction to dental or general anesthetic? ❑ yes ❑ no
15. Have you ever had any operations or surgery? ❑ yes ❑ no
Describe the problem and any complications
____

16. Have you ever been hospitalized? ❑ yes ❑ no
17. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ❑ yes ❑ no
18. Do your ankles swell during the day? ❑ yes ❑ no
19. Do you sleep on two or more pillows? ❑ yes ❑ no
20. Have you unintentionally lost or gained more than 10 pounds in the last year? ❑ yes ❑ no
21. Are you on a special diet? ❑ yes ❑ no
22. Does your occupation bring you in contact with blood, blood products or needles? ❑ yes ❑ no
23. (WOMEN) Are you pregnant or trying to get pregnant? ❑ yes ❑ no

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medicines change, I will inform the dentist at the next appointment without fail.

________ ______________________________

Date Patient, Parent or Guardian Signature

Review and Update

________ ______________________ ______________________________
________ ______________________ ______________________________

Date Changes in Health Status

Height ________; Weight ________; BP ________; Pulse ________; Resp. ________; Temp. ________

HEALTH COMMENTS & SUMMARY: ASA I II III IV

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