Medical History

INSTRUCTIONS

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission."

Patient's Initials_____ Dentist's Initials _____

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered and written in ink.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & phone # of your physician _____
2. Date of last visit to your doctor _____ Purpose of visit _____
3. Do you suffer from any disability?_____ If yes, describe _____

   _____
4. Have you ever, or do you now take illegal drugs?_____ If yes, what drugs, and when taken? _____

   _____

   Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.
5. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____

   _____
6. Do you now have, or have you ever had a venereal disease? _____ If yes, describe._____
7. Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____
8. For females: Are you pregnant?_____ If yes, when are you due? _____
9. For females: Are you taking birth control pills? _____ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*
10. Are you taking any drugs or medications?_____ If yes, list and describe amounts and purpose._____

    _____

    Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.
11. Have you ever had an allergic reaction to medication?_____ If yes, describe._____
12. Have you lost weight recently? _____ If yes, describe._____

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____

    _____
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____
15. Stomach or intestinal disease? _____