## Medical History

| | | CIRCLE | |
|---|---|---|---|
| 1. | Are you having pain or discomfort at this time? | YES | NO |
| 2. | Do you feel very nervous about having dental treatment? | YES | NO |
| 3. | Have you every had a bad experience in a dental office? | YES | NO |
| 4. | Have you been a patient in the hospital during the past two years? | YES | NO |
| 5. | Have you been under the care of a medical doctor during the past two years? | YES | NO |
| 6. | Have you taken any medicine or drugs during the past two years? | YES | NO |
| 7. | Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? | YES | NO |
| 8. | Have you ever had any excessive bleeding requiring special treatment? | YES | NO |
| 9. | When you walk up stairs or take a walk, do you every have to stop because of pain in your chest, or shortness of breath, or because you are very tired? | YES | NO |
| 10. | Do your ankles swell during the day? | YES | NO |
| 11. | Do you use more than 2 pillows to sleep? | YES | NO |
| 12. | Have you lost or gained more than 10 pounds in the last year? | YES | NO |
| 13. | Do you every wake up from sleep short of breath? | YES | NO |
| 14. | Are you on a special diet? | YES | NO |
| 15. | Has your medical doctor ever said you have a cancer or tumor? | YES | NO |
| 16. | Have you used Marijuana, Cocaine or other recreational drugs? | YES | NO |
| 17. | WOMEN: Are you pregnant or could you be pregnant? | YES | NO |
| | Are you using birth control pills? | YES | NO |
| | Do you anticipate becoming pregnant? | YES | NO |

18. Current physician _____ Address _____ Last visit _____

19. Circle any of the following which you have had or have at present:

| | | |
|---|---|---|
| Heart Failure | Emphysema | AIDS |
| Heart Disease or Attack | Cough | Hepatitis A (infectious) |
| Angina Pectoris | Tuberculosis (TB) | Hepatitis B (serum) |
| High Blood Pressure | Asthma | Liver Disease |
| Heart Murmur | Hay Fever | Yellow Jaundice |
| Rheumatic Fever | Sinus Trouble | Blood Transfusion |
| Congenital Heart Lesions | Allergies or Hives | Recreational Drug Usage |
| Scarlet Fever | Diabetes | Hemophilia |
| Artificial Heart Valve | Thyroid Disease | Venereal Disease (Syphilis, |
| Heart Pacemaker | X-ray or Cobalt Treatment | Gonorrhea) |
| Heart Surgery | Chemotherapy (Cancer, Leukemia) | Cold Sores |
| Artificial Joint | Arthritis | Genital Herpes |
| Anemia | Rheumatism | Epilepsy or Seizures |
| Stroke | Cortisone Medicine | Fainting or Dizzy Spells |
| Kidney Trouble | Glaucoma | Nervousness |
| Ulcers | Pain in Jaw Joints | Psychiatric Treatment |
| Sickle Cell Disease | Bruise Easily | |

20. Do you have any disease, condition, or problem not listed? YES NO

21 Name _____ Date _____ Date of Birth _____

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ASA
I
II
III
IV

CURRENT MEDICAL PROBLEMS

____ 1. _____
____ 2. _____
____ 3. _____
____ 4. _____

CURRENT MEDICATIONS

_ 1. _____
_ 2. _____
_ 3. _____
_ 4. _____

BP HT

____ ____

PULSE WT

____ ____

RESP TEMP
RATE

MODIFICATIONS TO THERAPY:

– General – – Specific –

_____

_____

_____

DENTISTRY DIAGNOSTIC SUMMARY _____

Reviewed by _____ Date _____ Update ___/___/___/___/___/___/___/___/___/___/___/___/

By ___/___/___/___/___/___/___/___/___/___/___/___/