

Dentist Anesthesiology
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Medical History Form

Date _____

Name _____ Last _____ First _____ Middle _____ Home Phone (____) _____

Address _____ Number Street _____ Business Phone (____) _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth / / Sex M F Height _____ Weight _____ Single _____ Married _____
mo day yr

Name of Spouse _____ Closest Relative _____ Phone (____) _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred By _____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- | | | |
|--|-----|----|
| 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. My last physical exam was on _____ | | |
| 4. Are you now under the care of a physician? | Yes | No |
| If so, what is the condition being treated? _____ | | |
| 5. The name and address of my physician(s) is _____ | | |
| _____ | | |
| _____ | | |
| 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? | Yes | No |
| If so, what was the illness or problem? _____ | | |
| 7. Are you taking any medicine(s) including non-prescription medicine? | Yes | No |
| If so, what medicine(s) are you taking? _____ | | |
| 8. Do you have or have you had any of the following diseases or problems? | | |
| a. Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease | Yes | No |
| b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | Yes | No |
| 1. Do you have chest pain upon exertion? | Yes | No |
| 2. Are you ever short of breath after mild exercise or when lying down? | Yes | No |
| 3. Do your ankles swell? | Yes | No |
| 4. Do you have inborn heart defects? | Yes | No |
| 5. Do you have a cardiac pacemaker? | Yes | No |
| c. Allergy | Yes | No |
| d. Sinus trouble | Yes | No |
| e. Asthma or hay fever | Yes | No |
| f. Fainting spells or seizures | Yes | No |
| g. Persistent diarrhea or recent weight loss | Yes | No |
| h. Diabetes | Yes | No |
| i. Hepatitis, jaundice or liver disease | Yes | No |
| j. AIDS or HIV infection | Yes | No |
| k. Thyroid problems | Yes | No |
| l. Respiratory problems, emphysema, bronchitis, etc. | Yes | No |
| m. Arthritis or painful swollen joints | Yes | No |
| n. Stomach ulcer or hyperacidity | Yes | No |
| o. Kidney trouble | Yes | No |
| p. Tuberculosis | Yes | No |
| q. Persistent cough or cough that produces blood | Yes | No |
| r. Persistent swollen glands in neck | Yes | No |
| s. Low blood pressure | Yes | No |
| t. Sexually transmitted disease | Yes | No |
| u. Epilepsy or other neurological disease | Yes | No |
| v. Problems with mental health | Yes | No |
| w. Cancer | Yes | No |
| x. Problems of the immune system | Yes | No |

- | | | |
|--|-----|----|
| 9. Have you had abnormal bleeding | Yes | No |
| a. Have you ever required a blood transfusion? | Yes | No |
| 10. Do you have any blood disorder such as anemia? | Yes | No |
| 11. Have you ever had any treatment for a tumor or growth? | Yes | No |
| 12. Are you allergic to or have you had a reaction to: | | |
| a. Local anesthetics | Yes | No |
| b. Penicillin or other antibiotics | Yes | No |
| c. Sulfa drugs | Yes | No |
| d. Barbituates, sedatives of sleeping pills | Yes | No |
| e. Aspirin | Yes | No |
| f. Iodine | Yes | No |
| g. Codeine or other narcotics | Yes | No |
| h. Other _____ | Yes | No |
| 13. Have you or any of your relatives had a bad reaction to intravenous sedatives or general anesthetics . | Yes | No |
| 14. Have you had any serious trouble associated with previous dental treatment | Yes | No |
| If so, explain _____ | | |
| _____ | | |
| 15. Do you have any disease, condition, or problem not listed above that you think I should know about? | Yes | No |
| If so, explain _____ | | |
| _____ | | |
| 16. Are you wearing contact lenses? | Yes | No |
| 17. Are you wearing removable dental appliances? | Yes | No |

WOMEN

- | | | |
|--|-----|----|
| 18. Are you pregnant? | Yes | No |
| 19. Do you have any problems associated with you menstrual period? | Yes | No |
| 20. Are you nursing? | Yes | No |
| 21. Are you taking birth control pills? | Yes | No |

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS MAJOR DENTAL TREATMENT: Yes No WHEN _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING (INDICATE WITH A ✓)

- | | | |
|--|--|--|
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Cigarettes, pipe or cigar smoking |
| <input type="checkbox"/> Bleeding gums. How long? _____ | <input type="checkbox"/> Unpleasant taste | <input type="checkbox"/> Chewing tobacco |
| <input type="checkbox"/> Food impaction | <input type="checkbox"/> Unfavorable dental experience | <input type="checkbox"/> Texture of toothbrush _____ |
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Frequency of brushing _____ |
| <input type="checkbox"/> Burning of tongue | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Dental floss frequency _____ |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Interdental stimulators |
| <input type="checkbox"/> Frequent blisters on lips or mouth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Water jet device |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Oral habits, i.e. fingernail biting | <input type="checkbox"/> Disclosing tablets or solution |
| <input type="checkbox"/> Unusual sounds in ear while eating | cheek biting, etc. | <input type="checkbox"/> Fluoride supplements |
| <input type="checkbox"/> TMJ problems | | |

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. I also consent to the use of still and/or video photography for educational purposes or verification of treatment.

Signature of Patient _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Date _____ Signature of Dentist _____