Distinctive Dental Services of New York, P.C.- Medical History Form

Date: _____

Name:_____ Home Ph:_____
Last First MI

Address:_____ Business Ph: _____

City: _____ State: _____ Zip Code:_____

Cell Ph:_____ E-mail: _____

Occupation: _____ Social Security No.: _____

Date of Birth: ___/___/_____ Sex: M / F Height: _____ Weight _____ Marital Status: S / M / W / Other

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

To whom may we thank for this kind referral? _____

_____

For the following circle *yes* or *no*. 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 the 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
5. The name and address of my physician(s): _____
   _____
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(s)?..... 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. Allergies…… 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 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 neurological disease..... Yes No
v. Problems with mental health..... Yes No
w. Cancer..... Yes No
x. Problems with 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 disorders 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 or sleeping pills..... Yes No
    e. Aspirin..... Yes No
    f. Iodine..... Yes No
    g. Codeine or other narcotics..... Yes No
    h. Latex..... Yes No
    i. Other_____
13. Have you or any of your relatives had a bad reaction to intravenous sedatives or general anesthetics?..... Yes No
    If so, please explain:_____
14. Have you had any serious trouble associated with previous dental treatment?..... Yes No
    If so, please explain:_____
15. Do you have any disease, condition, or problem not listed above that you think I should know about?..... Yes No
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 with your menstrual period?..... Yes No
20. Are you nursing?..... Yes No
21. Are you taking birth control pills?..... Yes No

I certify that I have read and understand the above. I acknowledge that questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, dentist anesthesiologist, or any 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/guardian:_____

Date:_____