Medical History Form Date: _____

Last Name:_____ First Name: _____ Middle Initial: _____

Address:_____ City:_____

State:_____ Zip:_____ EMail:_____

Home phone:_____ Work phone:_____ Cell Phone:_____

Occupation: _____ SSN: _____

Date of Birth:_____/_____/_____ Sex: M F Height:_____ Weight:_____

Marital Status: Single □ Married □ Name of Spouse/Partner:_____

Closest Relative: _____Phone: (____)_____

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

Employer: _____ 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 examination 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 heart valves, including heart murmur or rheumatic heart disease: ---------- Yes No

b. Cardiovascular disease (including 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 ankle 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. Respiration 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. Problem on 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? ---------- Yes No

11. Have you ever had any treatment for a tumor or growth? ----- Yes No

12. Are you allergic 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. Barbiturates, sedatives, or 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 had any serious trouble associated with any previous dental treatment? ---------- Yes No
    If so, explain: _____

14. Do you have any disease, condition, or problem not listed above that you think I should know about? ---------- Yes No
    If so, explain: _____

15. Are you wearing contact lenses? ---------- Yes No

16. Are you wearing removable dental appliances? ---------- Yes No

17. Do you smoke? ---------- Yes No
    If yes, how much?_____

18. Do you drink alcoholic beverages? ---------- Yes No
    If yes, how much and what type? _____

Women

19. Are you pregnant? ---------- Yes No

20. Do you have any problems associated with your menstrual period? ---------- Yes No

21. Are you nursing? ---------- Yes No

22. Are you taking birth control pills? ---------- Yes No

Chief Dental Complaint:_____

Any significant dental history we should know about? _____

_____

If you would rather mail us this form, simply fill out each field and then print this page by selecting the Print option on your File menu options above. Then sign the form and mail it to the address below.

Woodbury Smile Design
8035 Jericho Turnpike
Woodbury, NY. 11797

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.

_____
Signature of Patient

For completion by the dentist

Comments on patient interview concerning medical history: _____

_____

Significant findings from questionnaire or oral interview:_____

_____

Dental management considerations: _____

_____

Date: _____ Signature of Dentist:_____

Medical history update:

Date	Comments	Signature