DENZINGER
FAMILY DENTISTRY

Medical History Form

Today's Date _____

Name _____ Home Phone _____

Address _____ Business Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Email Address _____ Social Security No. _____

Occupation _____ Employer _____

Date of Birth ____/____/____ ☐ Male ☐ Female Height _____ Weight _____ ☐ Single ☐ Married

Contact Person _____ 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*, or check the appropriate box, whichever applies. Your answers are for your 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) _____
   _____
6. Have you had any serious illness, operation, eye surgery or hospitalization in the past 5 years? ..... Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medication(s) including non-prescription medication? ..... Yes No
   If so, what medicine(s) are you taking? _____
   _____
   Are you taking any herbal remedies? Kava Kava? St. John's Wort? Valerian Root? ..... Yes No
8. Do you have or have you had cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... Yes No
   a. Do you have or have you had damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease ..... Yes No
   b. Do you have chest pain upon exertion? ..... Yes No
   c. Are you ever short of breath after mild exercise or when lying down? ..... Yes No
   d. Do your ankles swell? ..... Yes No
   e. Do you have any prosthetic joints or pins in your body? ..... Yes No
   f. Do you have a cardiac pacemaker? ..... Yes No
   g. Do you have mitral valve prolapse or inborn heart defects? ..... Yes No
   h. Do you take blood thinners (i.e. Coumadin)? ..... Yes No
   i. Have you had a heart stent placed? ..... Yes No
9. Do you have or have you had any of the following diseases or problems? Check all that apply.

☐ Allergy	☐ Thyroid problems	☐ Persistent swollen glands in neck
☐ Sinus trouble	☐ Respiratory problems, emphysema, bronchitis, etc.	☐ Low blood pressure
☐ Asthma or hay fever	☐ Arthritis or painful swollen joints	☐ Epilepsy or other neurological disease
☐ Fainting spells or seizures	☐ Stomach ulcer or hyperacidity	☐ Problems with mental health
☐ Persistent diarrhea or recent weight loss	☐ Kidney trouble	☐ Cancer
☐ Diabetes	☐ Tuberculosis	☐ Problems of the immune system
☐ Hepatitis, jaundice or liver disease	☐ Persistent cough or cough that produces blood	
☐ AIDS or HIV infection		

10. Have you had abnormal bleeding? ..... Yes No
11. Do you have any blood disorder such as anemia? ..... Yes No
12. Have you ever had any treatment for a tumor or growth? ..... Yes No
13. Do you use cocaine or recreational drugs that may interact with dental local anesthetics? ..... Yes No
14. Are you allergic or have you had a reaction to: (Check all that apply)

☐ Local anesthetics	☐ Aspirin
☐ Penicillin or other antibiotics	☐ Iodine
☐ Sulfa drugs	☐ Codeine or other narcotics
☐ Barbiturates, sedatives, or sleeping pills	☐ Latex or other

More questions on back.

15. Are you happy with the appearance of your smile? Yes No
    If not, explain _____
16. Do you have any disease, condition, or problem not listed above that you think the dentist should know about? Yes No
    If so, explain _____
17. Are you wearing contact lenses? Yes No
18. Are you wearing removable dental appliances? Yes No
19. How long has it been since your last dental hygiene care appointment? _____
20. Do you have lumps or sores in your mouth now? Yes No
21. Have you ever been treated for gum or periodontal disease? Yes No
    If so, when? _____
    How was the infection treated? _____
22. Do hot, cold, or sweet beverages cause discomfort or pain in your mouth? Yes No
23. Do your gums bleed? Yes No
    If so, when? _____
24. Do you clench or grind your teeth? Yes No
25. Do you wear a night guard or a bite plate? Yes No
26. Do you use a CPAP or have you been treated for sleep apnea? Yes No
27. Do you smoke or use any other tobacco products? Yes No
28. Are you nervous about dental treatment? Yes No
29. Have you ever had an unpleasant experience in the dental office? Yes No
30. Are you interested in whitening your teeth? Yes No
31. Do you wear a sports guard during participation of sporting events? Yes No
32. What sports do you play? _____
33. Do you use an electric toothbrush? Yes No
34. Do you have chronic bad breath? Yes No
35. Do you experience frequent canker sores? Yes No
36. Do you get fever blisters - i.e., oral herpes? Yes No

WOMEN

37. Are you pregnant? Yes No
38. Are you nursing? Yes No
39. Are you taking birth control pills? Yes No

Chief Dental Complaint

_____

_____

_____

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.

_____ _____

Date Signature of Patient

FOR COMPLETION BY THE DENTIST

Comments on patient interview concerning medical history: _____

_____

_____

_____

_____ _____

Date Signature of Dentist

Medical history update:

Date:	Comments:	Signature:
_____	_____	_____
_____	_____	_____
_____	_____	_____