DOWNTOWN DENTAL CENTER

Medical History **Date_____**

Name _ _____
Last First Middle

Address _____
Street Apt. # City State Zip Code

Phone Number _____ E-mail address_____
Cell Work Home Optional

Social Security No._____ Marital Status_____ Name of Spouse _____

Date of Birth _____ Sex _____ Height _____ Weight _____ Referred By _____

Occupation _____ Employer _____
Name Street City State Zip Code

Insurance Company _____ Emergency Contact _____
Name Relationship Home Phone Work Phone

If you are completing this for someone else, please specify your relationship to that person _____

For the following questions, please circle yes or no, whichever applies. Your answers are for our records only and are considered confidential.

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?** **If so, what is the condition being treated? _____**	**Yes**	**No**
5.	**The name and address of my physician is _____**		
6.	**Have you ever had a serious illness or operation?** **If so, what was the problem? _____**	**Yes**	**No**
7.	**Have you been hospitalized or had a serious illness within the past five (5) years?** **If so, what was the problem? _____**	**Yes**	**No**
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	**Yes**	**No**
	b. Congenital heart lesions	**Yes**	**No**
	c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)	**Yes**	**No**
	1. Do you have pain in your chest upon exertion?	**Yes**	**No**
	2. Are you ever short of breath after mild exercise?	**Yes**	**No**
	3. Do your ankles swell?	**Yes**	**No**
	4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep?	**Yes**	**No**
	5. Do you have a cardiac pacemaker?	**Yes**	**No**
	d. Allergy	**Yes**	**No**
	e. Sinus trouble	**Yes**	**No**
	f. Asthma or hay fever	**Yes**	**No**
	g. Hives or skin rash	**Yes**	**No**
	h. Fainting spells or seizures	**Yes**	**No**
	i. Diabetes	**Yes**	**No**
	1. Do you have to urinate (pass water) more than six times a day?	**Yes**	**No**
	2. Are you thirsty most of the time?	**Yes**	**No**
	3. Does your mouth frequently become dry?	**Yes**	**No**
	j. Hepatitis, jaundice or liver disease	**Yes**	**No**
	k. Arthritis	**Yes**	**No**
	l. Inflammatory rheumatism (painful swollen joints)	**Yes**	**No**
	m. Stomach ulcers	**Yes**	**No**
	n. Kidney trouble	**Yes**	**No**
	o. Tuberculosis	**Yes**	**No**
	p. Do you have a persistent cough or cough up blood?	**Yes**	**No**
	q. Low blood pressure	**Yes**	**No**
	r. Venereal disease	**Yes**	**No**

	s. Epilepsy	Yes	No
	t. Psychiatric problems	Yes	No
	u. Cancer	Yes	No
	v. AIDS (Auto-Immunity Deficiency Syndrome)	Yes	No
9.	Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	Yes	No
	a. Do you bruise easily?	Yes	No
	b. Have you ever required a blood transfusion? If so, explain the circumstances _____	Yes	No
10.	Do you have any blood disorders such as anemia?	Yes	No
11.	Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?	Yes	No
12.	Are you taking any drugs or medications? If so, what? _____	Yes	No
13.	Are you taking any of the following:		
	a. Antibiotics or sulfa	Yes	No
	b. Anticoagulants (blood thinners)	Yes	No
	c. Medicine for high blood pressure	Yes	No
	d. Cortisone (steroids)	Yes	No
	e. Tranquilizers	Yes	No
	f. Antihistamines	Yes	No
	g. Aspirin	Yes	No
	h. Insulin, tolbutamide (Orinase) or similar drug	Yes	No
	i. Digitalis or drugs for heart trouble	Yes	No
	j. Nitroglycerin	Yes	No
	k. Oral contraceptive or other hormonal therapy	Yes	No
	l. Others _____		
14.	Are you allergic or have you reacted adversely to:	Yes	No
	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 _____		
15.	Have you had any serious trouble associated with any previous dental treatment? If so, explain _____	Yes	No
16.	Do you have any disease, condition, or problem not listed above that you think I should know about? If so, explain _____	Yes	No
17.	Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?	Yes	No
18.	Are you wearing contact lenses?	Yes	No
19.	Have you had anything to eat or drink in the last 4 hours?	Yes	No
20.	Are you wearing removable dental appliances?	Yes	No

Women

1.	Are you pregnant?	Yes	No
2.	Do you have any problems associated with your menstrual period?	Yes	No
3.	Are you nursing?	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 in the completion of this form.

_____
Signature of Patient

_____
Signature of Doctor