

Date
Chart #
Doctor #

Medical History

Patient Name:	Age	Personal Dentist:
Referred by:		Primary Care Physician:
Please give the name, address, and phone number of a person outside your household who could help us in contacting you.		
What other relatives have been treated by this office?		

Why did you come to our office? What do we need to help you with?	Do you or have you had any of the following	
	Yes	No
	Rheumatic Fever	
List the Surgeries that you have had:	Yes	No
	High Blood Pressure	
	Yes	No
Did you have general anesthesia?	Yes	No
	Stroke	
	Yes	No
List the medicines that you are presently taking:	Yes	No
	Heart Disease (heart attack, murmur, angina, valve replacement, bypass surgery)	
	Yes	No
What medicines are you allergic to? Penicillin Aspirin Demerol Codeine Sulfa Others?	Yes	No
	Lung Disease (asthma, emphysema, TB)	
	Yes	No
Do you drink alcohol?	Yes	No
	Kidney Disease	
	Yes	No
Do you currently use, or have you ever used or abused drugs?	Yes	No
	Liver Disease (hepatitis, jaundice, cirrhosis)	
	Yes	No
Family history of bleeding or anesthetic reactions?	Yes	No
	Epilepsy or Seizures	
	Yes	No
Are you being treated by a physician for any illness?	Yes	No
	Diabetes	
	Yes	No
Do you wish to talk to the doctor privately about anything special?	Yes	No
	Mental Illness	
	Yes	No
Is there anything regarding the appearance of your face, mouth, or teeth that you wish could be improved?	Yes	No
	Mental Handicap	
	Yes	No
	Yes	No
	Fever Blisters	
	Yes	No
	Yes	No
	TMJ (jaw joint) Problems	
	Yes	No
	Yes	No
	Bleeding Disorders	
	Yes	No
	Yes	No
	Have you ever had a blood transfusion?	
	Yes	No
	Yes	No
	Have you had hip or joint replacements?	
	Yes	No
	Yes	No
	Immune Diseases	
	Yes	No
	Yes	No
	Do you smoke cigarettes, cigars, pipes, or use smokeless tobacco?	
	Yes	No
	Yes	No
	Gastrointestinal Disease (ulcers, colitis, diverticulitis)	
	Yes	No
	Yes	No
	Arthritis	
	Yes	No
	Yes	No
	Ladies—Are you pregnant?	
	Yes	No

I understand the information I have provided on this form is essential to determine my surgical needs and that I have answered all questions truthfully. I will report any changes in my health history as soon as possible.

Signature (Parent or Guardian) _____ Date _____ OMSS _____