MEDICAL HEALTH HISTORY

NAME _____ **#**_____

Welcome! So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Name _____ Date of Birth _____ Age: _____ ❑ Male ❑ Female
Weight _____Height _____ If Patient is a Minor _____
(Name of Parent/Guardian)

MEDICAL HISTORY

Name and address of physician _____
When was your last physical examination? _____
Are you now under the care of a physician? Yes ❑ No ❑
If yes, for what reason? _____
Are you presently taking any medications/drugs/pills?
Please list: _____
_____
_____

Are you allergic (or have an adverse reaction) to:

❑ Penicillin ❑ Codeine ❑ Local Anesthetic ❑ None ❑ Other _____
❑ Aspirin ❑ Other antibiotics

Are you sensitive or allergic to latex? Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon? Have you had any unusual or unexplained reactions during a surgical procedure? No ❑ Yes ❑ Explain _____
_____

Do you have, or have you ever had any of the following: (yes or no)

Please check each box individually

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Heart Disease / Surgery	❑	❑	Tuberculosis	❑	❑	Liver disease	❑	❑	Sinus trouble	❑	❑	Neurological disorders
❑	❑	Heart murmur	❑	❑	Lung disease	❑	❑	Learning disability	❑	❑	Cancer	❑	❑	Prosthetic implants
❑	❑	Heart pacemaker	❑	❑	Diabetes	❑	❑	Arthritis/Rheumatism	❑	❑	Tumors	❑	❑	Artificial joint
❑	❑	Rheumatic fever	❑	❑	Epilepsy	❑	❑	Cortisone medicine	❑	❑	Chemotherapy	❑	❑	Venereal disease
❑	❑	Rheumatic heart disease	❑	❑	Anemia	❑	❑	Prolonged bleeding	❑	❑	Radiation therapy	❑	❑	HIV positive/AIDS/ARC
❑	❑	Congenital heart defects	❑	❑	Thyroid problems	❑	❑	Hemophilia	❑	❑	Stroke	❑	❑	Hearing impaired
❑	❑	Artificial heart valve	❑	❑	Chemical dependency	❑	❑	Sickle Cell Disease	❑	❑	Glaucoma	❑	❑	Organ transplant
❑	❑	Mitral valve prolapse	❑	❑	Kidney problems	❑	❑	Fainting spells	❑	❑	Psychiatric care	❑	❑	Removal of Spleen
❑	❑	Abnormal blood pressure	❑	❑	Hepatitis (circle one)	❑	❑	Asthma	❑	❑	Anorexia	❑	❑	Alcohol addiction
❑	❑	Ulcers			Type A B C	❑	❑	Emphysema	❑	❑	Bulimia	❑	❑	Drug dependency
									❑	❑	Scarlet Fever	❑	❑	Cognitive Disability

Do you currently smoke or use the following tobacco products?
❑ cigarettes ❑ cigars ❑ pipe ❑ chew ❑ none
Have you used tobacco products in the past? Yes ❑ No ❑ How long ago? _____

Do you drink alcoholic beverages? Yes ❑ No ❑ How much? _____
WOMEN: Are you pregnant? Yes ❑ No ❑
Do you take birth control medications? Yes ❑ No ❑

Have you had any other serious illness, hospitalization or accident? Yes ❑ No ❑
If yes, please explain _____
_____

DR COMMENTS

_____ _____
DR SIGNATURE **DATE**

BP _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient signature _____ Date _____
(PARENT/GUARDIAN OF A MINOR)

Previous dentist's name: _____

Do you have any dental problems now? Yes No

If yes, please describe. _____

_____

Have you ever experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (Joint, ear, side of face)	Yes	No
Difficulty opening/closing mouth?	Yes	No
Pain or soreness in face muscles or around ears?	Yes	No
Would you like to change the appearance of your teeth?	Yes	No
Do you clench or grind your teeth?	Yes	No

Do you feel anxiety about having dental treatment?	Yes	No

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Pressure?	Yes	No
Does food tend to become caught between your teeth?	Yes	No

Do you snore? **Yes No**

Your snoring is: **slightly louder than breathing / as loud as talking / louder than talking / very loud (heard in adjacent rooms)**

How often do you snore? **Nearly every day / 1-2 times a week / 3-4 times a week / 1-2 times a month / never or nearly never**

Has your snoring ever bothered people? **Yes No**

Has anyone noticed that you quit breathing during your sleep? **Nearly every day / 1-2 times a week / 3-4 times a week / 1-2 times a month / never or nearly never**

How likely are you to fall asleep during the following activities? **0=never 1=slight chance 2=moderate chance 3=high chance**

A. Sitting and reading ____
B. Watching TV ____
C. Sitting, inactive in a public place ____
D. A passenger in a car for an hour without a break _____
E. Lying down to rest in the afternoon ____
F. Sitting and talking to someone ____
G. Sitting quietly after a lunch without alcohol ____
H. In a car while stopped in traffic ____

Total: _____

During your wake time, do you feel tired or not up to par? **Yes No**

Have you ever nodded off or fallen asleep while driving a vehicle? **Yes No**

Do you currently have a CPAP device? **Yes No** Do you currently wear the device? **Yes No**

Would you like to be contacted by Midwest Apnea Solutions if this form indicates that you may possibly suffer from a sleep breathing disorder? **Yes No**

THIS PORTION TO BE FILLED OUT ONLY IF PATIENT IS A MINOR

Parent or/Legal Guardian: _____ DOB: _____

Has your child ever received a blow or injury to his head or teeth? Yes ☐ No ☐

Describe: _____

Has your child ever been treated with X-ray or radiation therapy? Yes No

Does your child have any habits we should know about, such as:

Poor Eating Habits ☐ Thumb Sucking ☐ Pacifier ☐ Bottles ☐ Other: _____

Does your child receive fluoride in:

Drinking water at home Yes ☐ No ☐ By Prescription Yes ☐ No ☐

Has your child had any unpleasant dental experiences? Yes ☐ No ☐

Has your child ever had orthodontic treatment? Yes ☐ No ☐ When? _____

Does your child experience any of the following?

Abnormal Growth and Development ☐ Bedwetting ☐ Behavioral and Learning Challenges ☐
Daytime Sleepiness ☐ Hyeractivity or ADHD ☐ Nighttime snoring with occasional pauses ☐
Gasping or Choking ☐ Sleep Disruption ☐

Signature of Patient or Guardian: _____

Patient Name: _____ **Staff Signature:** _____