MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **Date:** _____

Person Completing Form: _____ Relationship _____

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: _____
3. Yes No Have you been hospitalized, had a serious illness or operation in the past 5 years? _____
4. Yes No Do you have, or have you had any of the following: 4a. Blood Transfusions: _____ When? (date) _____
   4b. Organ Transplant: Type _____ Date _____ 4c. Prosthetic Heart Valve: Date _____
5. Yes No Are you being treated by a physician now? For what? _____

Primary Physician: _____ Phone _____ City & State _____

Date of last physical examination: _____ Date of last blood test/work up: _____

Other Physicians & Specialists

Name: _____ Speciality _____ Phone _____ City _____

Name: _____ Speciality _____ Phone _____ City _____

B. HAVE YOU EVER EXPERIENCED?

6. Yes No Difficulty Swallowing
7. Yes No Dizziness
8. Yes No Fainting Spells
9. Yes No Jaundice
10. Yes No Persistent Cough, Coughing up Blood
11. Yes No Recent Weight Loss, Fever, Night Sweats
12. Yes No Ringing in Ear
13. Yes No Sleep Apnea
14. Yes No Chronic Snoring
15. Yes No Wound or Sore that bleeds easily, or does not heal

If you answered "Yes" to any of the above:

16. Do you know the reason why? _____

C. DO YOU HAVE OR HAVE YOU HAD:

17. Yes No Alchoholism
18. Yes No Anemia
19. Yes No Angina
20. Yes No Anxiety: ☐ General Anxiety ☐ Dental Anxiety
21. Yes No Arthritis, Rheumatism
22. Yes No Artificial Joint, Prosthesis: List: _____ date _____
23. Yes No Asthma: If yes: Do you use an Inhaler? Yes No
24. Yes No Breathing Problems or Shortness of Breath
25. Yes No Cancer: Type _____ Diagnosed When? _____
    If Yes, Did you receive: ☐ Chemotherapy ☐ Radiation Treatment
26. Yes No Congenital Heart Defects
27. Yes No Congestive Heart Failure
28. Yes No Coronary Heart Disease
29. Yes No COPD: If yes: Do you use an inhaler? Yes No
30. Yes No Diabetes: ☐ Type I ☐ Type II
31. Yes No Epilepsy or other Seizure Problems
32. Yes No Excessive Bleeding
33. Yes No Gerd, Gastro-Esophageal Reflux Disease
34. Yes No Glaucoma or any other Eye Disease
35. Yes No Hay Fever; Skin or Food Allergies; Hives; Allergies in general
36. Yes No Hearing Impairment
37. Yes No Heart Attack: Date _____
38. Yes No Heart Murmur
39. Yes No Heart Valve(s) Damage/Mitral Valve Prolapse
40. Yes No Heart Condition ☐ Pacemaker date _____
41. Yes No Hemophilia or other Bleeding Disorders
42. Yes No Hepatitis: ☐ Hep A ☐ Hep B ☐ Hep C
43. Yes No Herpes
44. Yes No High Blood Pressure
45. Yes No HIV
46. Yes No Immune Disorders-Lupus, HIV, AIDS-ARC
47. Yes No Infective Endocarditis
48. Yes No Kidney, Bladder Diseases
49. Yes No Liver Disease
50. Yes No Low Blood Pressure
51. Yes No Lupus
52. Yes No Measles
53. Yes No Mental Health Issues
54. Yes No Mitral Valve Prolapse
55. Yes No Mobility Impairment
56. Yes No Mumps
57. Yes No Psychiatric Condition: ☐ Under Treatment Now
    If yes, list here: _____
58. Yes No Rheumatic Fever
59. Yes No Scarlet Fever
60. Yes No Sexually Transmitted Disease (STD or VD):
61. If yes, list type: _____
62. Yes No Skin Problems
63. Yes No Sinus Problems
64. Yes No Stroke: Date _____
65. Yes No Tonsillitis: ☐ Removed Date: _____
66. Yes No TB, Tuberculosis, Emphysema, or Lung Disorder
67. Yes No Thyroid Condition: ☐ Hyper ☐ Hypo
68. Yes No Ulcers, Acid Reflux, or Stomach Problems
69. Yes No Visual Impairment: ☐ Contact Lenses

D. FOR WOMEN:

70. **Yes No N/A** Are you currently pregnant?

Estimated Delivery Date: _____

Gestation: _____

71. **Yes No N/A** Are you Nursing?

72. **Yes No N/A** Are you currently taking any birth control prescriptions?*

> **Note*: Antibiotics such as penicillin may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional methods of birth control.

E. DO YOU TAKE OR HAVE TAKEN:

73. Yes No Alcohol: How often: ____Daily _____Weekly _____Sometimes

74. Yes No Fosamax/Boniva or other Biphosphonate drugs

75. Yes No Phen Phen diet Pills or any other diet pills

76. Yes No Recreational Drugs: Any Rehab? Yes No Dates:_____

77. Yes No Tobacco in any form? Type_____Quantity_____Date Started_____Date Quit: _____

Type_____Quantity_____Date Started_____Date Quit: _____

78. Yes No Other recreational drug: _____

F. MEDICATIONS

79. Are you taking ANY drugs, medications or treatments at this time? **Yes** **No**

a.) **Yes No** Do you take blood thinners?

b.) **Yes No** Are you taking or have you taken any steroid/cortisone therapy in the last two years?

c.) **Yes No** Have you ever been told, by a physician or dentist, that you need to pre-medicate prior to any dental treatment?

80. List Prescription Medications: _____

_____

81. **List Over The Counter Medications (such as Aspirin, Advil, Allergy, sleeping aids, etc.):** _____

82. **List Vitamins and Supplements:** _____

_____

G. ALLERGIES

a. Are you allergic to, or have you had an adverse reaction to:

83. Yes No Acrylics
84. Yes No Amoxicillin
85. Yes No Aspirin
86. Yes No Codeine
87. Yes No Dental Anesthesia (local), Novocaine or Epinephrine
88. Yes No Fluoride
89. Yes No Foods: List_____
(cont'd at right -->)
90. Yes No Gluten
91. Yes No Nuts List: _____
92. Yes No Milk, Dairy
93. Yes No Latex
94. Yes No Metals or Jewelry
95. Yes No Penicillin
96. Yes No Spices, Flavorings or Colorings:
97. Yes No Sulfa
98. Yes No Tetracycline

b. Have you had an allergic reaction or unusual response to ANY medications, drugs, pills or treatments, etc.

99. **Yes No** Please list allergies:_____

_____

H. ALL PATIENTS:

100. **Yes No** Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

Certify and Consent:

I certify that all the preceding information is correct and if there is ever any change in health, or medication, this practice will be informed of the change(s) without fail. I consent to allow the practice to contact any healthcare provider(s) and to have the patient's health information released to aid in the care and treatment I also consent to allow diagnosis, proper health care and treatment to be performed by Lehigh Valley Smile Designs for the below named individual until further notice.

Signature_____**DATE** _____

Signature_____**DATE**_____

(parent or guardian if patient is a minor)