MEDICAL HISTORY

Name:	Address:	City, State, Zip Code:
Home Phone Number: ( ) -	Cell Phone Number: ( ) -	Work Number: ( ) -

Do you had any of the following diseases or problems?

1) YES NO Active Tuberculosis
2) YES NO Persistent cough greater than a three-week duration
3) YES NO Cough that produces blood

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

CIRCLE THE APPROPRIATE ANSWER (leave blank if you do not understand the question):

4) YES NO Is your general health good?
5) YES NO Has there been a change in your health within the last year?
If YES, when & why?
6) YES NO Are you being treated by a physician now? Who? For what?

HAVE YOU EXPERIENCED:

7) YES	NO	Chest Pain (angina)	17) YES	NO	Dizziness
8) YES	NO	Swollen Ankles	18) YES	NO	Ringing in ears
9) YES	NO	Shortness of breath	19) YES	NO	Headaches
10) YES	NO	Recent weight loss	20) YES	NO	Fainting spells
11) YES	NO	Persistent cough	21) YES	NO	Blurred vision
12) YES	NO	Bleeding problems	22) YES	NO	Seizures
13) YES	NO	Sinus problems	23) YES	NO	Excessive thirst
14) YES	NO	Difficulty swallowing	24) YES	NO	Frequent urination
15) YES	NO	Frequent vomiting	25) YES	NO	Dry mouth
16) YES	NO	Joint pain	26) YES	NO	Jaundice

DO YOU HAVE OR HAVE YOU HAD:

27) YES	NO	Heart disease	41) YES	NO	HIV, AIDS
28) YES	NO	Heart attack **DATE:**	42) YES	NO	Tumors
29) YES	NO	Heart Murmurs	43) YES	NO	Arthritis, rheumatism
30) YES	NO	Heart Defects	44) YES	NO	Eye disease
31) YES	NO	Stroke **DATE:**	45) YES	NO	Skin disease
32) YES	NO	Hardening of arteries	46) YES	NO	Anemia
33) YES	NO	Asthma, TB, emphysema	47) YES	NO	VD (HPV, syphilis, gonorrhea)
34) YES	NO	Hepatitis/Liver disease	48) YES	NO	Herpes
35) YES	NO	Stomach problems/Ulcers	49) YES	NO	Kidney, bladder disease
36) YES	NO	Autoimmune diseases	50) YES	NO	Thyroid, adrenal disease
37) YES	NO	High blood pressure	51) YES	NO	Diabetes
38) YES	NO	Cancer	52) YES	NO	High cholesterol
39) YES	NO	Osteoperosis	53) YES	NO	Psychiatric care
40) YES	NO	Allergies **Please list all known allergies:**			

DO YOU HAVE OR HAVE YOU HAD:

54) YES	NO	Radiation treatment **DATE:**	59) YES	NO	Hospitalization
55) YES	NO	Chemotherapy **DATE:**	60) YES	NO	Blood transfusion
56) YES	NO	Prosthetic heart valve **DATE:**	61) YES	NO	Pacemaker
57) YES	NO	Artificial joint **DATE:**	62) YES	NO	Stent **DATE:**
58) YES	NO	Other Surgeries **PROCEDURE & DATE:**			

ARE YOU TAKING:

63) YES NO Are you or have you taken Bisphosphonates (Fosamax, Reclast, Boniva, etc)
64) YES NO Recreational drugs
65) YES NO Over the counter drugs (including aspirin)
66) YES NO Tobacco in any form
67) YES NO Alcohol
68) YES NO Do you have or have you had any other disease or medical problems NOT listed on this form?
If yes, please explain: _____
69) YES NO Prescription drugs **Please list all over the counter and prescription medications you are taking:** _____
_____

70) YES	NO	**Women:** Are you pregnant or nursing	71) YES	NO	**Women:** Taking birth control pills

NOTE: Both clinician and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's/Guardian's Signature_____ Date_____

Clinician Only Comments:_____
_____
_____

Reviewed By: Date:

NORTHWOODS DENTISTRY