Medical History

(Please answer all Questions)

Name of Family Physician: _____ Date of last visit to physician: _____

Are there any medical specialists you see regularly? Specialty: _____

Date of last time *complete physical exam:* _____ Examining doctor: _____

- Has this patient been advised by a physician that they require an *antibiotic prior to dental treatment?* ☐No If ☐Yes, Antibiotic:_____ How is antibiotic given? _____

Pre-Medicate? ☐No
Rx: _____

- This patient's general health at this time is:..... ☐Good, ☐Fair, ☐Poor Comment? _____
- Is this patient presently under the care of a physician? ..... ☐No, If ☐Yes, For what? _____
- Is this patient presently taking medications?..... ☐No, If ☐Yes, which medications: _____
- Has this patient had tonsils or adenoids removed?..... ☐No, If ☐Yes, ☐Tonsils (on date_____) ☐Adenoids (on date_____) _____
- Does this patient have a *Chronic Illness?* ..... ☐No, If ☐Yes, Comment? _____
- Has this patient ever had a serious illness? ..... ☐No, If ☐Yes, Comment? _____
- Has this patient ever been *Hospitalized?* ..... ☐No, If ☐Yes, For what? _____
- Is this patient allergic to antibiotics (penicillin, etc)?..... ☐No, If ☐Yes, which medications: _____
- Does this patient have anesthetic reactions?..... ☐No, If ☐Yes, ☐Local ☐General: _____
- Is this patient allergic to anything else?..... ☐No, If ☐Yes, what? ☐Sulfa Drugs ☐Aspirin ☐Ibuprofen ☐Environmental ☐Metals ☐Plastics ☐Latex Comments: _____

Allergy Alert? ☐No _____

- **Does this patient now have, or ever had any of the following problems?**

☐No ☐Yes Rheumatic Fever	☐No ☐Yes Hepatitis (type?_____)	☐No ☐Yes Diabetes
☐No ☐Yes Endocarditis	☐No ☐Yes Aids or HIV Positive	☐No ☐Yes Epilepsy
☐No ☐Yes Heart Condition	☐No ☐Yes Tuberculosis	☐No ☐Yes Stroke
☐No ☐Yes Heart Pacemaker	☐No ☐Yes Lived with tuberculin person	☐No ☐Yes Stomach Ulcers
☐No ☐Yes Heart Angina	☐No ☐Yes Respiratory Lung Disease	☐No ☐Yes Tonsillitis
☐No ☐Yes Heart Attack (coronary)	☐No ☐Yes Asthma	☐No ☐Yes Headaches
☐No ☐Yes Mitral Valve Prolapse	☐No ☐Yes Venereal Disease	☐No ☐Yes Earaches
☐No ☐Yes Congenital Heart Disease	☐No ☐Yes Herpes (Oral Cold Sores)	☐No ☐Yes Jaw Pain
☐No ☐Yes Artificial Heart Valve	☐No ☐Yes Inflammatory Rheumatism	☐No ☐Yes Jaw Clicking (noises)
☐No ☐Yes Heart Surgery (date: _____)	☐No ☐Yes Arthritis	☐No ☐Yes Attention Deficit Syndrome (ADD)
☐No ☐Yes Heart Murmur	☐No ☐Yes X-Ray (radiation) cancer therapy	☐No ☐Yes Other Emotional Problems (note below)
☐No ☐Yes High Blood Pressure	☐No ☐Yes Glaucoma	
☐No ☐Yes Low Blood Pressure	☐No ☐Yes Fainting Spells	
☐No ☐Yes Blood Disorders/Bleeding Problems	☐No ☐Yes Kidney Trouble	
☐No ☐Yes Anemia	☐No ☐Yes Liver Disease	

Medical Alert? ☐No _____

Please comment on ☒Yes responses: _____

- Does this patient have any other medical problems not listed? ☐No, If ☐Yes, Comment: _____

Patient's Growth History:

What is this patient's height? _____Ft. _____ In.
Child's present age: _____years, _____ months
Is child adopted? ☐No ☐Yes
Any recent signs of increased growth? ☐No ☐Yes
Comments: _____

If a *BOY*, has his voice changed? ☐No ☐Yes
If a *GIRL*, has she started menstruation? ☐No ☐Yes
MOTHER'S present height: _____Ft. _____ In.
FATHER'S present height: _____Ft. _____ In.

Additional Growth?
☐No ☐Yes
☐Possibly

Patient's Family History of:

	If ☒**YES**, which family member	Comments on Family Histories:
☐No ☐Yes Diabetes		
☐No ☐Yes Cancer or Skin Cancer		
☐No ☐Yes Infectious Disease		☐TB ☐Hepatitis ☐HIV+ ☐Aids
☐No ☐Yes Heart Disease		
☐No ☐Yes High Blood Pressure		
☐No ☐Yes Organ Disease		☐Liver ☐Kidney ☐Lung
☐No ☐Yes Emotional Problems		☐Anxiety ☐Depression
☐No ☐Yes Stroke		
☐No ☐Yes Arthritis		

Other family history comments: _____

Medical History Reviewed: Dr.'s Initials: _____