HEARTLAND DENTAL GROUP MEDICAL HISTORY

Patient's Name _____ D.O.B. _____

Your Physician's Name and Address _____

CIRCLE ONE

1. Have you been a patient in the hospital during the last two years?.....YES NO
2. Have you been under the care of a medical doctor during the past two years?..YES NO
3. Have you taken any medicine or drugs during the past two years?.....YES NO
4. Are you currently taking any medicine or drugs?.....YES NO
   a) If yes, what?_____

_____

_____

_____

5. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?.....YES NO
   Other: _____
6. Have you ever had any excessive bleeding requiring special treatment?.....YES NO
7. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Persistent Cough	HIV Infection
Angina Pectoris	Tuberculosis (TB)	HepatitisA (Infectious)
High Blood Pressure	Asthma	Hepatitis B (Serum)
Heart Murmur	Hay Fever	Liver Disease
Rheumatic Fever	Sinus Trouble	Yellow Jaundice
Congenital Heart Lesions	Allergies or hives	Blood Transfusion
Scarlet Fever	Diabetes	Drug Addiction
Artificial Heart Valve	Thyroid Disease	Hemophilia
Heart Pacemaker	X-ray or Cobalt Treatment	Venereal Disease
Heart Surgery	Chemotherapy (cancer, leukemia)	Cold Sores
Artificial Joint	Arthritis	Genital Herpes
Anemia	Rheumatism	Epilepsy or Seizures
Stroke	Cortisone Medicine	Fainting or Dizzy Spells
Kidney Trouble	Glaucoma	Nervousness
Ulcers	Pain in Jaw Joints	Psychiatric Treatment
Latex Allergies	Bruise Easily	Sickle Cell Disease

8. Do you have any disease or condition not listed? YES NO
   If yes, please list:_____

_____

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?...YES NO
10. Do your ankles swell during the day?.....YES NO
11. Do you use more than 2 pillows to sleep?.....YES NO
12. Have you lost or gained more than 10 pounds in the past year?.....YES NO
13. Do you ever wake up from sleep short of breath?.....YES NO
14. Are you on a special diet?.....YES NO

CIRCLE ONE

15. Has your medical doctor ever said you have cancer or a tumor? Y N
16. WOMEN: Are you pregnant now? YES NO
    Are you practicing birth control YES NO
    Do you anticipate becoming pregnant YES NO
17. Are you having pain or discomfort at this time?..... YES NO
18. Do you feel very nervous about having dental treatment? YES NO
19. Have you ever had a bad experience in the dental office?.YES NO
20. Do your gums bleed when you brush?.....YES NO
21. Are you troubled with bad breath?.....YES NO
22. Have you ever had: __Injury to your face, jaw or teeth?
    __Oral Surgery?
    __Orthodontic treatment?
    __Periodontal (gum) surgery?
23. Are you happy with the appearance of your teeth.....YES NO
24. Do you have trouble chewing your food?.....YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

_____ _____

Date Signature of Patient, Parent or Guardian

UPDATES