Baechtold
FAMILY DENTISTRY

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Personal Medical History Form

ALL RESPONSES ARE KEPT CONFIDENTIAL

Medical History

Question	Yes	No
Are you in good health?	☐ Yes	☐ No
Has there been ANY change in your general health in the past year?	☐ Yes	☐ No
Are you now under a physician's care for a particular problem?	☐ Yes	☐ No

Do you have or have you ever had any of the following:

- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Organ Transplant
- ☐ Vascular Stents
- ☐ Mitral Valve Prolapse
- ☐ Artificial Joints or Implants
- ☐ Heart Valve Replacement
- ☐ Surgically Placed Pins or Rods

Question	Yes	No
If any of the above are circled, have you ever premedicated?	☐ Yes	☐ No

Do you have or have you ever had:

	Condition	Yes	No
a.	Congenital heart disease	☐ Yes	☐ No
b.	Cardiovascular disease (heart trouble, heart attack aneurysm, coronary artery disease. angina. high or low blood pressure, stroke, palpitations, heart surgery, pacemaker)	☐ Yes	☐ No
c.	Lung disease (asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)	☐ Yes	☐ No
d.	Neurological or Psychological disorders (convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder, breakdown or stress medication)	☐ Yes	☐ No
e.	Blood disease (anemia, bleeding tendency, blood transfusion, do you bruise easily)	☐ Yes	☐ No
f.	Liver disease (jaundice, hepatitis)	☐ Yes	☐ No
g.	Kidney disease	☐ Yes	☐ No
h.	Diabetes	☐ Yes	☐ No
i.	Thyroid disease (goiter)	☐ Yes	☐ No
j.	Arthritis	☐ Yes	☐ No
k.	Back pain (surgery or endometriosis)	☐ Yes	☐ No
l.	Glaucoma	☐ Yes	☐ No
m.	Stomach ulcer or colitis	☐ Yes	☐ No
n.	Frequent or recurring mouth sores	☐ Yes	☐ No
o.	Cancer	☐ Yes	☐ No
p.	Radiation (x-ray) treatment of cancer	☐ Yes	☐ No
q.	Sinus or nasal problems	☐ Yes	☐ No
r.	Marijuana or other "street drugs"?	☐ Yes	☐ No
s.	Any disease, drugs, or transplant operation that has depressed your immune system (AIDS OS or HIV)?	☐ Yes	☐ No
t.	Recurrent infections of any kind?	☐ Yes	☐ No
u.	Problems with anesthesia?	☐ Yes	☐ No
v.	Do you smoke cigarettes or use smokeless tobacco? Past:________ or Present: _________	☐ Yes	☐ No
w.	Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?	☐ Yes	☐ No
x.	Do you wish to speak with the doctor privately about anything?	☐ Yes	☐ No
	Women: Are you pregnant, planning pregnancy, or nursing?	☐ Yes	☐ No

Dental History

Question	Yes	No
1. When was your last checkup?		
2. Were x-rays taken?	☐ Yes	☐ No
3. Do your gums bleed?	☐ Yes	☐ No
4. Do you have any sore or sensitive teeth?	☐ Yes	☐ No
5. Do you have any sores, swelling, or fever blisters in your mouth?	☐ Yes	☐ No
6. Problems with tooth extractions?	☐ Yes	☐ No
7. Have you ever had a traumatic experience in a dental office?	☐ Yes	☐ No

8. Please list ALL MEDICATIONS you are taking:

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9. Please list all ALLERGIES:

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I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR. FALSIFICATION OF HEALTH HISTORY CAN END IN RELATIONSHIP TERMINATION.

____
Signature of person completing this form

Date ______________________________

Medical Update (DO NOT SIGN HERE UNLESS UPDATING INFO)
I have read my health history & I confirm that it adequately states past and present conditions. All changes were made in RED.

____
Signature of person completing this form

Date ______________________________