Drs. Woodard & Sundell

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Oral & Maxillofacial, Periodontal and Implant Surgery

MEDICAL HISTORY FORM

Name: ______________________ Date: ______________________

Date of Birth: ______________________ Sex: M / F Height: __________ Weight: __________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

		YES	NO
1.	Are you in good health?	❑	❑
2.	Has there been any change in your health in the past year?	❑	❑
3.	My last physical exam was on ____/____/____		
4.	Are you now under the care of a physician?	❑	❑
	If so, for what condition? ______________________		
5.	The name and address of my physician is: ______________________		
6.	Have you had any serious illness, significant operation or hospitalization within the past 5 years?	❑	❑
7.	Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills	❑	❑
	If so, please list ______________________		
8.	Do you have or have you had any of the following diseases or problems?		
a.	Damaged heart valves, artificial valves or heart murmur	❑	❑
b.	Rheumatic Heart Disease	❑	❑
c.	Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition	❑	❑
1.	Chest pain upon exertion?	❑	❑
2.	Shortness of breath after mild exercise?	❑	❑
3.	Do your ankles swell?	❑	❑
d.	Allergies	❑	❑
e.	Sinus trouble	❑	❑
f.	Asthma or hay fever	❑	❑
g.	Fainting spells or seizures	❑	❑
h.	Diabetes	❑	❑
i.	Hepatitis, jaundice or liver disease	❑	❑
j.	Frequent or recurring mouth sores	❑	❑
k.	Thyroid problems	❑	❑
l.	Respiratory problems, emphysema, bronchitis, etc.	❑	❑
m.	Arthritis or painful, swollen joints including jaw joint (TMJ)	❑	❑
n.	Stomach ulcer or hyperacidity	❑	❑
o.	Kidney trouble	❑	❑
p.	Tuberculosis	❑	❑
q.	Persistent cough or cough that produces blood	❑	❑
r.	Persistent swollen neck glands	❑	❑
s.	Low blood pressure	❑	❑
t.	Epilepsy or neurological disorder	❑	❑
u.	Are you taking vitamins or homeopathic remedies	❑	❑
v.	Cancer	❑	❑
w.	Any disease, drug or transplant operation that has depressed your immune system	❑	❑
9.	Have you had abnormal bleeding?	❑	❑
a.	Have you ever required a blood transfusion?	❑	❑
10.	Do you have any blood disorder such as anemia?	❑	❑
11.	Have you ever had treatment for a tumor or growth?	❑	❑

		YES	NO
12. Are you allergic to or have you had a reaction to:			
a. Local anesthetics	Yes	❑	❑
b. Penicillin or antibiotics	Yes	❑	❑
c. Sulfa drugs	Yes	❑	❑
d. Barbiturates or sleeping pills	Yes	❑	❑
e. Aspirin	Yes	❑	❑
f. Iodine	Yes	❑	❑
g. Codeine or other narcotics	Yes	❑	❑
h. Latex or rubber products	Yes	❑	❑
i. Other	Yes	❑	❑
13. Have you had any serious trouble associated with previous dental treatment?	Yes	❑	❑

If so, explain:____

14. Do you have any other condition or disease you think the doctor should know about?	Yes	❑	❑

If so, explain:____

15. Are you wearing contact lenses?	Yes	❑	❑
16. Are you wearing removable dental appliances?	Yes	❑	❑
17. Do you wish to talk with the doctor privately about anything?	Yes	❑	❑

Women

18. Are you pregnant or trying to become pregnant	Yes	❑	❑
19. Do you have problems associated with your menstrual period?	Yes	❑	❑
20. Are you nursing?	Yes	❑	❑
21. Are you taking birth control pills?	Yes	❑	❑

Chief Dental Complaint: ____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date:____________________ Patient's Signature:______________________________

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: ______________________________

Significant findings from questionnaire or oral interview: ______________________________

Dental management considerations: ______________________________

Date:____________________ Doctor's Signature:______________________________

Medical History Update:

Date	Comments	Signature