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MEDICAL HISTORY RECORD

NAME _____ AGE: _____ DATE _____

What treatment are you seeking? _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

ALL RESPONSES ARE KEPT CONFIDENTIAL

- 1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam?
4. Are you now under a physician's care for a particular problem? Y N
5. Have you had any serious illnesses, operations or hospitalizations? Y N
6. Have you had any adverse effects from dental treatment? Y N
7. Do you have or have you ever had:
A. Rheumatic fever or rheumatic heart disease? Y N
B. Congenital heart disease? Y N
C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, mitral valve prolapse, palpitations, heart surgery, pacemaker)? Y N
D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Y N
E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown? Y N
F. Bleeding disorder, anemia, bleeding tendency, blood transfusion, do you bruise easily? Y N
G. Liver disease (jaundice, hepatitis)? Y N
H. Kidney disease? Y N
I. Diabetes? Y N
J. Thyroid disease (goiter)? Y N
K. Arthritis? Y N
L. Stomach ulcers or colitis? Y N
M. Glaucoma? Y N
N. Frequent or recurring mouth sores? Y N
O. Implants placed anywhere in your body (heart valve, hip, knee)? Y N
P. Cancer? Y N
Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
R. Sinus or nasal problems? Y N
S. Any disease, drugs or transplant operation that has depressed your immune system? Y N
T. Recurrent infections of any kind? Y N
8. Are you using or taking any of the following:
A. Tagamet? Y N
B. Thyroid medications? Y N
C. Antibiotics or sulfa drugs? Y N
D. Anticoagulants (blood thinners)? Y N
E. High blood pressure medicine? Y N
F. Steroids (cortisone, etc.)? Y N
G. Tranquilizers (valium, etc.)? Y N
H. Insulin, diabenese, or similar drug? Y N
I. Digitalis, inderal, nitroglycerin, calcium channel blockers, procordia or other heart medicine? Y N
J. Aspirin or ibuprofen (motrin, naprosyn, etc.)? Y N
K. Marijuana or other "street" drugs? Y N
L. Antihistamines or decongestants (seldane)? Y N
M. Are you taking any other regular medications, pills or drugs? Y N
9. Are you allergic or had bad reaction to:
A. Local anesthetic (novocaine, etc.)? Y N
B. Penicillin, amoxicillin, cephalosporins or other antibiotics? Y N
C. Barbiturates, sedatives, etc.? Y N
D. Aspirin or ibuprofen? Y N
E. Codeine or other pain killers? Y N
F. Latex or rubber products? Y N
G. Other allergies or reactions? Y N
10. Do you smoke or chew tobacco? Y N
11. Do you use alcohol? Y N
12. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders? Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
14. Do you wish to talk with the doctor privately about anything? Y N
15. FOR WOMEN ONLY
A. If you are using oral contraceptives or contraceptive injection it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your physician for further guidance.
B. If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester.
C. Is there any chance of you being pregnant? Y N
D. Do you wish to have a pregnancy test? Y N
E. Are you breastfeeding? Y N
F. Are you taking hormone replacement therapy? Y N

ANSWER THESE QUESTIONS ONLY IF YOU ARE PLANNING TO BE MADE SLEEPY TODAY:

Have you had anything to eat or drink, including water, within the last 8 hours? Answering this question falsely can cause serious complications.. Yes No

Who is to drive you home today? _____

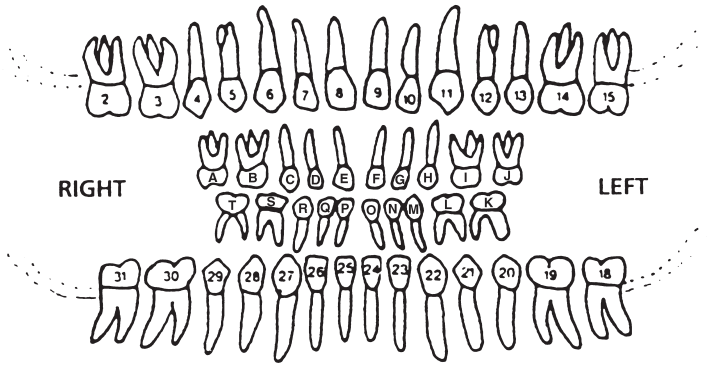
Do you now have a cold and/or cough? Yes No Are you able to breathe through your nose? Yes No

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.

X Signature of person completing Health History Dr's Initials

MEDICAL UPDATE: I HAVE READ MY HEALTH HISTORY DATED ___/___/___ AND CONFIRM THAT IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS.

NAME: _____ DATE: _____



(S.O.A.P. EXAM)

SUBJECTIVE _____

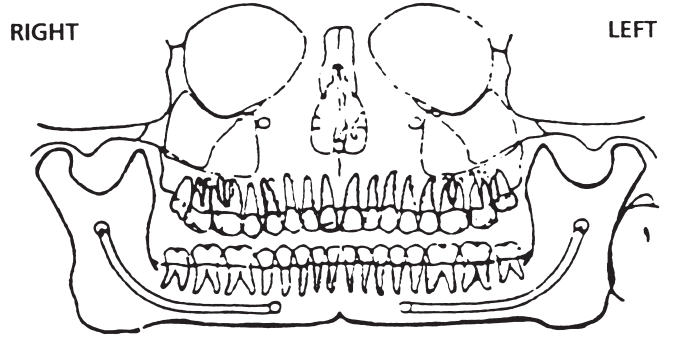
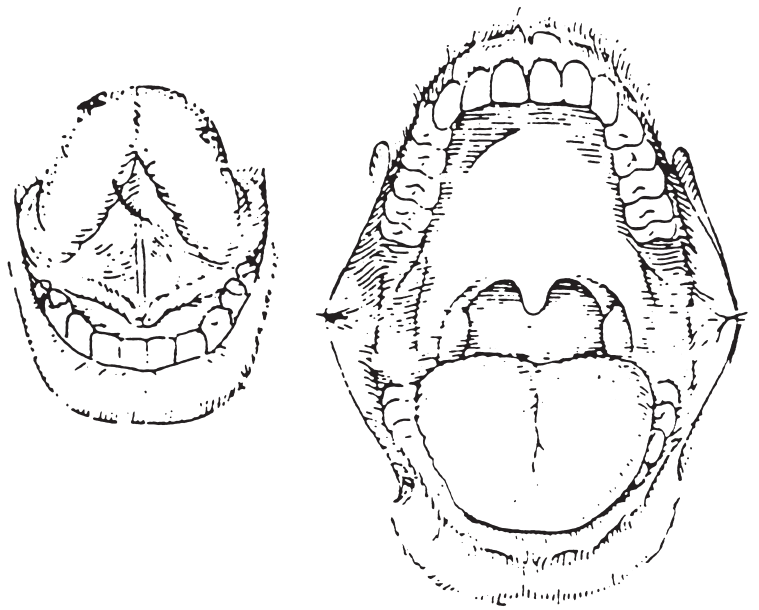
OBJECTIVE (+ & -) _____

ASSESSMENT (DX) _____

PLAN OR TX. _____

ALLERGIES _____

MEDICATIONS _____



RADIOGRAPHS AVAILABLE

Panoramic PA Occlusal

Cephalometric TMJ Other: _____

EXAM BP _____ P _____ T _____

Date _____ BP _____ P _____ T _____

Date _____ BP _____ P _____ T _____