

Chip L. Hill, D.D.S.

Medical History Form

Name _____ Sex _____ Date of Birth: _____

Address _____

Telephone # _____ Height _____ Weight _____

Date _____ Occupation _____ Marital Status _____

Directions

If the answer is YES to the question, check "YES."

If the answer is NO to the question, check "NO."

Answer all questions by checking either YES or NO, and fill in all blank spaces when indicated.

Answers to the following questions are for our records only and will be considered confidential.

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| a. Has there been any change in your general health with in the past year? | Yes | No |
| 2. My last physical examination was on _____ | | |
| 3. Are you now under the care of a physician? | Yes | No |
| a. If so, what is the condition being treated? _____ | | |
| 4. The name and address of my physician is? (This is an absolute must) _____ | | |
| 5. Have you had any serious illness or operation? | Yes | No |
| a. If so, what was the illness or operation? _____ | | |
| 6. Have you ever been hospitalized or had a serious illness within the past five (5) years? | Yes | No |
| a. If so, what was the problem? _____ | | |
| 7. Do you have or have you had any of the following diseases or problems? | | |
| a. Rheumatic fever or rheumatic heart disease..... | Yes | No |
| b. Congenital heart lesions/heart murmur | Yes | No |
| c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | Yes | No |
| 1) Do you have pain in chest upon exertion? | Yes | No |
| 2) Are you ever short of breath after mild exercise?..... | Yes | No |
| 3) Do your ankles swell? | Yes | No |
| 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? | Yes | No |
| d. Allergy..... | Yes | No |
| e. Asthma or hay fever | Yes | No |
| f. Hives or skin rash | Yes | No |
| g. Fainting spells or seizures/epilepsy | Yes | No |
| h. Diabetes..... | Yes | No |
| 1) Do you have to urinate (pass water) more than six times a day?..... | Yes | No |
| 2) Are you thirsty much of the time? | Yes | No |
| 3) Does your mouth frequently become dry? | Yes | No |
| i. Hepatitis, jaundice or liver disease..... | Yes | No |
| j. HIV | Yes | No |
| k. Arthritis..... | Yes | No |
| l. Artificial joints | Yes | No |
| m. Inflammatory rheumatism (painful or swollen joints)..... | Yes | No |
| n. Stomach ulcers | Yes | No |
| o. Kidney trouble | Yes | No |
| p. Tuberculosis..... | Yes | No |

q. Do you have persistent cough or cough up blood?	Yes	No
r. Low blood pressure.....	Yes	No
s. Venereal disease.....	Yes	No
t. Other _____		
8. Have you ever had abnormal bleeding with previous extractions, surgery or trauma?	Yes	No
a. Do you bruise easily?.....	Yes	No
b. Have you ever required a blood transfusion?	Yes	No
If so, explain the circumstances _____		
9. Do you have any blood disorder, such as anemia?.....	Yes	No
10. Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck?	Yes	No
11. Are you taking any drug or medicine?	Yes	No
If so, what? _____		
12. Are you taking any of the following?		
a. Antibiotics or sulfa drugs.....	Yes	No
b. Anticoagulants (blood thinners)	Yes	No
c. Medicine for high blood pressure.....	Yes	No
d. Cortisone (steroids)	Yes	No
e. Tranquilizers.....	Yes	No
f. Aspirin	Yes	No
g. Insulin, tolbutamide (Orinase) or similar drug	Yes	No
h. Digitalis or drugs for heart problems.....	Yes	No
i. Nitroglycerin	Yes	No
j. Antihistamine.....	Yes	No
k. Oral contraceptive or other hormonal therapy	Yes	No
l. Other.....	Yes	No
13. Are you allergic or reacted adversely to any of the following?		
a. Local anesthetics.....	Yes	No
b. Penicillin or other antibiotics.....	Yes	No
c. Sulfa drugs	Yes	No
d. Barbiturates, sedatives, or sleeping pills	Yes	No
e. Aspirin	Yes	No
f. Iodine.....	Yes	No
g. Codeine or other narcotics	Yes	No
h. Other _____		
14. Have you ever had any serious trouble with any previous dental treatment?	Yes	No
If so, explain _____		
15. Do you have any disease, condition, or problem not listed above that you think I should know? .	Yes	No
If so, explain _____		
16. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation	Yes	No
17. Are you wearing contact lenses?.....	Yes	No

Women Only

18. Are you pregnant?.....	Yes	No
19. Do you have any problems associated with your menstrual period?	Yes	No

Chief Dental Complaint:

By signing below I acknowledge that the above information is accurate, and true. I also agree to notify you directly if there are ever any changes in this information.

Signature of patient

Signature of Dentist