Dr. John C. Stone, DDS – Medical History Form

Name: _____ Date: ____/____/20__

MEDICAL HISTORY

(Please circle yes or no)

1	Has there been a recent change in your health If yes, please explain, _____	No	Yes
2	When was your last physical examination, _____		
3	Are you under the care of a physician? If yes, condition: _____	No	Yes
4	Have you been hospitalized or had a serious illness within the last 5 years? If yes, what was the problem, _____	No	Yes

5. Do you have or have you had, any of the following? (Please circle yes or no)

YES	NO	Artificial limbs or Heart valve	YES	NO	Arthritis or Rheumatism	YES	NO	Hepatitis or Liver disease
YES	NO	Organ transplant	YES	NO	Heart murmur	YES	NO	Psychiatric or Emotional disease
YES	NO	Asthma or Hay fever	YES	NO	Kidney problems	YES	NO	Tested for the AIDS Antibodies
YES	NO	Fainting spells or Seizures	YES	NO	Venereal disease	YES	NO	Rheumatic Fever or Heart problems
YES	NO	Tuberculosis	YES	NO	Pacemaker	YES	NO	Abnormal bleeding or Blood disorders
YES	NO	Radiation Therapy	YES	NO	Diabetes	YES	NO	High Low Blood pressure
YES	NO	Other _____						

6	Do you have any difficulty breathing through your nose	No	Yes
7	Are you currently taking any medication? If yes, please list, _____	No	Yes
8	Are you allergic or do you have addictions to any drugs or medications such as Penicillin, Codeine, Cocaine, Aspirin, or Alcohol? If yes, Please list. _____	No	Yes
9	Are you aware of any lumps in your mouth?	No	Yes
10	Have you ever had a bad reaction to local or general anesthetic?	No	Yes
11	Have you ever had excessive bleeding after tooth extraction?	No	Yes
12	Do you have any disease, condition, or other problems not listed above that I should know about? If so, please list. _____	No	Yes
13	Do you wish to discuss your medical history privately with the doctor?	No	Yes
	WOMEN ONLY		
1	Are you pregnant? If so, how many months _____	No	Yes
2	Are you taking birth control pills?	No	Yes
3	Are you breast feeding?	No	Yes
	HEALTH HISTORY		
1	What concerns you most about your teeth? _____		
2	Are you aware of any dental problems at this time?	No	Yes
3	When was your last dental visit? _____		
4	When was the last time you had x-rays taken in a dental office? _____		
5	When was your last dental cleaning? _____		
6	Have you had any of the following treatment? Orthodontics (braces), Endodontics (Root canal), Periodontics (Gum therapy), If yes, please specify, _____	No	Yes
7	Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth?	No	Yes
8	Are you aware of grinding or clenching your teeth?	No	Yes
9	Do your gums bleed?	No	Yes
10	Do you suffer anxiety or gagging during dental procedures?	No	Yes
11	Do you or have you worn partials or dentures?	No	Yes
12	Do you want to avoid dentures> Why? _____	No	Yes
13	Are you unhappy with the appearance of your teeth?	No	Yes
14	What changes would you make about your mouth? _____		
15	Interests and hobbies? _____		

Patient signature: _____ Date: ____/_____/20____

Parent or Guardian Signature (if a minor) _____ Date: ____/_____/20____