Barrett L. Bartell, D.D.S., P.A.
Tom C. Howorth, D.D.S.

Medical History Form

Name: ______________________________ Date: ______________

Address: ____

Phone: ____________________ Sex: M F Date of Birth: ____________

For what reason have you come to our office: ______________________________

In Case of Emergency Contact __________________ Phone No. __________ Relationship ______

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

1. Are you in good health? .... Yes No
2. Has there been any change in your health in the past year? .... Yes No
3. My last physical exam was on ______________
4. Are you now under the care of a physician? .... Yes No
   If so, for what condition? ______________________________

5. The name of my physician is: ______________________________
6. Have you had any serious illness, significant operation or hospitalization within the past *5* years? .... Yes No
   If Yes, List: ______________________________
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies or diet pills? .... Yes No

   List medications and reasons: ______________________________

   ____

8. Do you have or have you had any of the following diseases or problems:
   a. Damaged heart valves, artificial valves or heart murmur? .... Yes No
   b. Rheumatic Heart Disease? .... Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition? .... Yes No
      1. Chest pain upon exertion? .... Yes No
      2. Shortness of breath after mild exercise? .... Yes No
      3. Do your ankles swell? .... Yes No
   d. Glaucoma? .... Yes No
   e. Sinus trouble? .... Yes No
   f. Asthma? .... Yes No
   g. Fainting spells or seizures? .... Yes No
   h. Diabetes? .... Yes No
   i. Hepatitis, jaundice or liver disease? .... Yes No
   j. Frequent or recurring mouth sores? .... Yes No
   k. Thyroid problems? .... Yes No
   1. Respiratory problems, emphysema, bronchitis, etc? .... Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ)? .... Yes No
   n. Artificial Joint? If Yes, List ______________________________ Yes No
   o. Stomach ulcer or hyperacidity? .... Yes No
   p. Kidney trouble? .... Yes No
   q. Tuberculosis? .... Yes No
   r. Persistent cough or cough that produces blood? .... Yes No
   s. Persistent swollen neck glands? .... Yes No
   t. Low blood pressure? .... Yes No
   u. Epilepsy or neurological disorder? .... Yes No
   v. Are you taking vitamins or homeopathic remedies? .... Yes No
   w. Cancer? .... Yes No
   x. Any disease, drug or transplant operation that has depressed your immune system? .... Yes No
      If yes, list ______________________________

(Please complete other side of form)

9. a. Have you had abnormal bleeding? .... Yes No

If yes, when? ___________________

b. Have you ever required a blood transfusion? .... Yes No

If yes, when? ___________________

10. Do you have any blood disorder such as anemia? .... Yes No

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 No

b. Penicillin or antibiotics? .... Yes No

c. Sulfa drugs? .... Yes No

d. Barbiturates or sleeping pills? .... Yes No

e. Aspirin? .... Yes No

f. Iodine? .... Yes No

g. Codeine or other narcotics? .... Yes No

h. Latex or rubber products? .... Yes No

i. Other? .... Yes No

13. Have you had any serious trouble associated with previous dental treatment? .... Yes No

If so, explain: ____

14. Do you have any other condition or disease you think the doctor should know about? .... Yes No

If so, explain: ____

15. Are you wearing contact lenses? .... Yes No

16. Are you wearing removable dental appliances? .... Yes No

17. Do you wish to talk with the doctor privately about anything? .... Yes No

18. Social History

a. Tobacco use .... Yes No

1. Cigarettes _________________ Quantity_______________ Years_____________

2. Other_______________________ Quantity_______________ Years_____________

b. Alcohol Use .... Yes No

1. Amount per week________________________

c. Recreational Drug Use .... Yes No

Women

19. Are you pregnant or trying to become pregnant? .... Yes No

20. Do you have problems associated with your menstrual period? .... Yes No

21. Are you nursing? .... Yes No

22. Are you taking birth control pills? .... Yes No

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:

____

____

Date: ___________________________________Doctor's Signature:____

Medical History Update:

Date	Comments	Signature