# PATIENT MEDICAL HISTORY

Complete the appropriate forms online and send them to us prior to your visit at Best Smiles. This will help us make your visit as pleasant and efficient as possible.

**Name** *

First | Middle | Last

**Date** *

**Social Security Number** *

**Physician's Name** *

First | Last

**Physician's Phone** *

**Office Address** *

Street Address

City | State

ZIP Code

**Approximate date of last physical exam** *

**Color / Nationality**

## Vital Signs

**Height** *

**Weight** *

**Respiration Rate**

**Pulse Rate**

**Blood Pressure**

## Health Questions

**Are you in good health?** *

- ◯ Yes
- ◯ No

**Has there been a change in your general health in the last 5 years? ***

- ◯ Yes
- ◯ No

**Are you now under the care of a physician? ***

- ◯ Yes
- ◯ No

**Have you been hospitalized within the last 5 years? ***

- ◯ Yes
- ◯ No

**Do you have / had any of the following heart diseases? (Check all that Apply)**

- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart lesion
- ☐ Heart attack
- ☐ Coronary insufficiency
- ☐ Stroke
- ☐ Coronary occlusion
- ☐ Heart murmur
- ☐ Congenital heart lesion
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Arteriosclerosis
- ☐ Mitro valve proplapse

- [ ] History of rheumatic, rheumatic heart disease, or scarlet fever
- [ ] Artificial heart valve
- [ ] Cardiac stent within the last six months
- [ ] Repaired heart defect (PFO)
- [ ] Irregular heartbeat
- [ ] Chest pain
- [ ] Pacemaker or implantable defibrillator
- [ ] Other

**Do you have / had any of the following respitory diseases? (Check all that Apply)**

- [ ] Asthma
- [ ] Emphysema
- [ ] Bronchitis
- [ ] Tuberculosis
- [ ] Other

**Do you have / had any of the following liver diseases? (Check all that Apply)**

- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Jaundice
- [ ] Other

**Do you have / had any of the following gastrointestinal diseases or disorders? (Check all that Apply)**

- [ ] Stomach or duodenal ulcers

- [ ] Gastric reflux or GERD
- [ ] Celiac disease
- [ ] Colitis
- [ ] Other

**Do you have / had any of the following neurological disorders? (Check all that Apply)**

- [ ] Seizures
- [ ] Epilepsy
- [ ] Convulsions
- [ ] Loss of consciousness
- [ ] ADD
- [ ] ADHD
- [ ] Prion disease
- [ ] Headaches
- [ ] Other

**Do you have / had any of the following kidney diseases? (Check all that Apply)**

- [ ] Glomerulonephritis
- [ ] Phelonephritis
- [ ] Other

**Do you have / had any of the following blood disorders? (Check all that Apply)**

- [ ] Anemia
- [ ] Sickle cell
- [ ] Thrombocytopenia

- [ ] Hemophilia
- [ ] Leukemia
- [ ] Other

**Do you get severe or migraine headaches? ***

- ◯ Yes
- ◯ No

**Do you get frequent fainting spells (syncope)? ***

- ◯ Yes
- ◯ No

**Do you have any psychiatric treatment, mental disorders, or emotional difficulties**

- [ ] Anxiety
- [ ] Depression
- [ ] Schizophrenia
- [ ] Nervous tension

**Do you have / had any of the following autoimmune diseases? (Check all that Apply)**

- [ ] Rheumatoid arthritis
- [ ] Lupus
- [ ] Scleroderma
- [ ] Sjorgrens syndrom
- [ ] Other

**Do you have / had any of the following endocrine problems? (Check all that Apply)**

- [ ] Diabetes
- [ ] Hypothyroid
- [ ] Hyperthyroid
- [ ] Parathyroid problems
- [ ] Other

**Do you have / had any of the following joint disorders? (Check all that Apply)**

- [ ] Arthritis
- [ ] Bursitis
- [ ] Other

**Do you have / had any of the following venereal disease or STD? (Check all that Apply)**

- [ ] Syphilis
- [ ] Gonorrhea
- [ ] Human papilloma virus
- [ ] Chlamydia
- [ ] Herpes
- [ ] Other

**Do you have HIV / AIDS? ***

- ◯ Yes
- ◯ No

**Do you have / had any of the following bone disorders? (Check all that Apply)**

- [ ] Osteopenia
- [ ] Osteoporosis

- [ ] Osteonecrosis
- [ ] Osteoarthritis
- [ ] Other

**Have you had a serious head or neck injury? ***

- ◯ Yes
- ◯ No

**Do you have / had any of the following vision disorders? (Check all that Apply)**

- [ ] Glaucoma
- [ ] Corrected vision with contacts or glasses

**Do you have hearing loss? ***

- ◯ Yes
- ◯ No

**Does / did anyone in your family have diabetes? ***

- ◯ Yes
- ◯ No

**Have you had abnormal bleeding with previous extractions, surgery, or trauma? ***

- ◯ Yes
- ◯ No

**Have you ever required a blood transfusion? ***

- ◯ Yes
- ◯ No

**Have you had surgery, chemotherapy, and / or radiation therapy for a tumor or cancer? ***

- ◯ Yes
- ◯ No

**Do you have frequent colds or infections? ***

- ◯ Yes
- ◯ No

**Do you have / had any of the following symptoms? (Check all that Apply)**

- ☐ Pain in the chest upon exertion
- ☐ Shortness of breath after mild exercise or physical exertion
- ☐ Swollen ankles
- ☐ Shortness of breath when you lie down
- ☐ Require an extra pillow when you sleep to make breathing easier
- ☐ Fatigue easily and frequently
- ☐ Suffer from chest pains which radiate to the left arm, jaw, or neck
- ☐ Cough up blood
- ☐ Urinate more than six (6) times per day
- ☐ Mouth becomes dry frequently
- ☐ Suffer from nausea frequently
- ☐ Vomiting blood
- ☐ Have frequent indigestion, heartburn, gastric reflux
- ☐ Thirsty most of the time
- ☐ Have abdominal cramping
- ☐ Suffer from loss of appetite

- [ ] Experienced a recent gain or loss of ten (10) pounds
- [ ] Have blood tinged or tarry stools
- [ ] Always hungry, eating but losing weight
- [ ] Bruise easily
- [ ] Have nose bleeds frequently
- [ ] Had cuts or sores that won't heal within one (1) week
- [ ] Lumps or swelling in the mouth

**Check if you are allergic to or have reacted adversely to any of the following**

- [ ] Local anesthetics
- [ ] Penicillin or other antibiotics
- [ ] Sulfa drugs
- [ ] Aspirin
- [ ] Iodine
- [ ] Cinnamon
- [ ] Barbiturates/sedative/sleeping pills
- [ ] Codeine or other narcotic
- [ ] Walnut Oil
- [ ] Zinc
- [ ] Nickel
- [ ] Gold
- [ ] Silver
- [ ] Rag weed
- [ ] Latex

- [ ] Other

**Have you been taking any of the following medications for a long period of time (Check all that Apply):**

- [ ] Antibiotics or sulfa drugs
- [ ] Anticoagulants (blood thinners), Coumadin, Heparin, Persantine
- [ ] Medicine for high blood pressure
- [ ] Cortisone (steroids), prednisone
- [ ] Tranquilizers
- [ ] Antihistamines
- [ ] Aspirin, Ibuprofen, Advil, Motrin
- [ ] Insulin, Tolbutamide (orinase), Glucophage, or similar drug
- [ ] Nitroglycerine
- [ ] Digitalis, beta-blockers, or any drugs for heart conditions
- [ ] Antacids
- [ ] Vomiting blood
- [ ] Birth control pills
- [ ] Herbal supplements, Vitamin E (greater than 400 units)
- [ ] Bisphosphonate (IV or oral), Fosamax, Boniva, Actonel

**Have you had any psychiatric care for emotional or nervous problems? ***

- ◯ Yes
- ◯ No

**Have you had any drug addiction problems? ***

- ◯ Yes

- ◯ No

**Do you use any recreational drugs? ***

- ◯ Yes
- ◯ No

**Do you use medical marijuana? ***

- ◯ Yes
- ◯ No

**Are you breathing? ***

- ◯ Yes
- ◯ No

**Are you employed in any situation which exposes you regularly to large amounts of sunlight, X-rays, or other ionizing radiation? ***

- ◯ Yes
- ◯ No

**How often do you consume alcoholic beverages? ***

**Are you now, or have you been a smoker? ***

- ◯ Yes
- ◯ No

**Are you now, or have you been a tobacco chewer? ***

- ◯ Yes

- [ ] No

**Does someone in your household snore? ***

- [ ] Yes
- [ ] No

**(Women) Are you or do you have any reason to suspect that you are pregnant? ***

- [ ] Yes
- [ ] No

**Do you have any other disease, condition, problem, or concern not listed above that you think we should know about? ***

- [ ] Yes
- [ ] No

**Do you agree to advise us in the future of any change in your medical history? ***

- [ ] Yes
- [ ] No

SUBMIT