LOREE SCHWEIGER NICHOLAS, D.D.S., P.C.

MEDICAL HISTORY FORM

NAME: _____ **DATE:** _____

For the following questions, circle Yes or No, whichever applies. Your answers are for our records only and will be considered confidential. Please note, during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Are you in good health? Yes No
Has there been any change in your general health within the past year? Yes No
Your last physical exam was on: _____
Are you now under the care of a physician? Yes No
If yes, what is the condition being treated? _____
_____
The name and address of your physician(s) _____
_____
Have you had any illness, operation, surgery or ever been hospitalized? Yes No
If answered yes, please explain. _____
_____
_____
Are you currently taking any medication(s) including non-prescription? Yes No
If so, what medication(s) please list: _____
_____
_____

Do you have or have you had any of the following diseases or problems?

Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? ..... YES...NO
Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, high blood pressure, arteriosclerosis, stroke)? ..... YES...NO
Do you smoke?..... YES ...NO
Are you ever short of breath after mild exercise or when lying down? .... YES...NO
Do your ankles swell? ..... YES...NO
Do you have inborn heart defects? ..... YES...NO
Do you have a cardiac pacemaker?..... YES...NO
Asthma, hay fever, seasonal allergies?..... YES...NO
Fainting spells, seizures, or epilepsy?..... YES...NO
Diabetes?..... YES...NO
Hepatitis, jaundice, or liver disease?..... YES...NO
AIDS or HIV infection?..... YES...NO
Thyroid problems?..... YES...NO
Respiratory problem, emphysema, bronchitis, TB?..... YES...NO
Arthritis or painful swollen joints?..... YES...NO

OVER

Stomach ulcer or hyperacidity?..... YES...NO
Kidney trouble?..... YES...NO
Persistent cough?..... YES...NO
Persistent swollen glands in neck?..... YES...NO
Blood pressure abnormalities?..... YES...NO
Sexually transmitted disease?..... YES...NO
Cancer?..... YES...NO
Problems of the immune system?..... YES...NO
Have you had abnormal bleeding?..... YES...NO
Have you ever required a blood transfusion?..... YES...NO
Do you have a blood disorder such as anemia?..... YES...NO
Are you allergic or have you had a reaction to any of the following:

- Local anesthetics?..... YES...NO
- Penicillin or other antibiotics?..... YES ...NO
- Barbiturates, sedatives, sleeping pills?..... YES...NO
- Codeine or other narcotics?..... YES...NO
- Nickel..... YES...NO
- Other_____

Women...Are you pregnant? YES...NO Are you nursing? YES...NO Are you taking birth control pills? YES...NO

List any other conditions, diseases, or problems not listed above_____
_____

Last dental visit:_____Treatment rendered:_____

Chief dental complaint?_____

Whom may we thank for referring you?_____

I certify that I read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I acknowledge that there will be office charges for failed or missed appointments without a 24 hour notice of cancellation. We appreciate 24 hour notice of cancellation.

Signature of Patient or Guardian _____

Date _____ Signature of Dentist _____