Medical Health History

G² Dental
family dentistry

Patient's Name: _____

Date of Birth: _____

Physician Name: _____ Physician Telephone: _____

Physician Address: _____

Mark your response to indicate if you have had any of the following diseases or problems.
If you have a disease or problem that is not listed below, write the disease or condition in the space on the back of this form.

Date of last physical examination: _____

Yes	No	
☐	☐	Any changes in your health within the past year?

Yes	No	**Cardiovascular**
☐	☐	High/low blood pressure
☐	☐	Irregular heart beat
☐	☐	Heart surgery
☐	☐	Heart failure
☐	☐	Damaged heart valve
☐	☐	High cholesterol
☐	☐	Heart infection
☐	☐	Stroke
☐	☐	Rheumatic heart disease/ rheumatic fever
☐	☐	Heart defect/heart murmur
☐	☐	Heart trouble/heart attack/ angina
☐	☐	Chest pain
☐	☐	Pacemaker
☐	☐	Congenital heart problem
☐	☐	Mitral valve prolapse

Yes	No	**Hematologic**
☐	☐	Anemia
☐	☐	Sickle cell anemia
☐	☐	Abnormal bleeding
☐	☐	Taking blood thinners
☐	☐	Blood transfusion

Yes	No	**Respiratory**
☐	☐	Emphysema/bronchitis
☐	☐	Sleep apnea
☐	☐	Asthma/hay fever/ seasonal allergies
☐	☐	Lung/breathing problems
☐	☐	Sinus trouble
☐	☐	Shortness of breath
☐	☐	Scarlet fever
☐	☐	Persistent cough
☐	☐	Cough that produces blood
☐	☐	Tuberculosis
☐	☐	Tonsillitis

Yes	No	**Endocrine**
☐	☐	Diabetes
☐	☐	Thyroid problem
☐	☐	Hypoglycemia

Yes	No	**Renal**
☐	☐	Kidney disorder
☐	☐	Dialysis

Yes	No	**Immune**
☐	☐	Past use of steroids
☐	☐	Delayed healing

Yes	No	**Musculoskeletal**
☐	☐	Fibromyalgia
☐	☐	Lupus
☐	☐	Sjogren's Syndrome
☐	☐	Osteoporosis
☐	☐	Taken <u>any</u> meds for bone loss prevention, ie: Fosamax or Boniva
☐	☐	Arthritis/rheumatism
☐	☐	Joint replacement/implant

Yes	No	**Gastrointestinal**
☐	☐	Acid reflux/GERD
☐	☐	Irritable bowel syndrome
☐	☐	Stomach ulcer

Yes	No	**Hepatic**
☐	☐	Liver disease
☐	☐	Jaundice
☐	☐	Hepatitis

Yes	No	**Neurologic**
☐	☐	Epilepsy/seizures
☐	☐	Parkinson's Disease
☐	☐	Multiple sclerosis
☐	☐	Headaches/migranes

Yes	No	**Skin**
☐	☐	Hives or skin rash
☐	☐	Other skin lesions
☐	☐	Cold sores/fever blisters

Yes	No	**Eyes/Ears**
☐	☐	Glaucoma
☐	☐	Impaired vision/contact lens
☐	☐	Impaired hearing/hearing aids

Yes	No	**Mental Health**
☐	☐	Bipolar disorder
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Eating disorders
☐	☐	Sleep disorder
☐	☐	Dementia
☐	☐	Learning disorders
☐	☐	Mental health care
☐	☐	Nervousness

Yes	No	**Infections**
☐	☐	HIV positive/AIDS
☐	☐	Sexually transmitted disease

Yes	No	**Allergies**
☐	☐	Local anesthetic
☐	☐	Antibiotics/penicillin
☐	☐	Aspirin/ibuprofen
☐	☐	Acetaminophen (Tylenol)
☐	☐	Codeine/narcotics
☐	☐	Metals
☐	☐	Iodine
☐	☐	Latex
☐	☐	Sulfa drugs
☐	☐	Other _____
☐	☐	Food/environmental please list _____

Yes	No	**Other**
☐	☐	Cancer
☐	☐	Cancer treatment/Radiation
☐	☐	Chemotherapy (Cancer, Leukemia)
☐	☐	Tobacco use
☐	☐	Alcohol use
☐	☐	Chemical dependency
☐	☐	Street/recreational/illicit drug use
☐	☐	Back problems
☐	☐	Tumors
☐	☐	Swelling of feet/ankles/ hands
☐	☐	Fainting/dizzy spells
☐	☐	Cortisone treatment
☐	☐	Unexplained weight loss
☐	☐	Taken Redux

Please list any disease, condition, or problem you have that is not listed on the other side.

Please list any hospitalizations or surgeries you have had.

Please list all medications you are taking. (Including vitamins and supplements)

	YES	NO
Have you been diagnosed with sleep apnea?	☐	☐
If yes: do you wear a CPAP?	☐	☐
A sleep appliance?	☐	☐
Have you noticed or been told of any of the following while you are sleeping?		
Snoring, heavy or loud breathing?	☐	☐
Break or pause in breathing?	☐	☐
Gasp, choke, or struggle to breathe?	☐	☐
Restless or agitated sleep? Grinding teeth?	☐	☐
Abnormal head posture (hyper-extension, etc.)?	☐	☐
Have you noticed any of the following during the day?		
Difficulty waking?	☐	☐
Wake with headaches and/or sore teeth/jaw muscles?	☐	☐
Tired during day?	☐	☐
Teeth sensitive to cold?	☐	☐
Gum tissue recession?	☐	☐

Women Only:

Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you using a birth control method?	☐	☐