Medical History Form: For the following quetions, *circle yes or no,* whichever applies. Your answers are for our records only and will be considered confidential. Please note that 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.

Yes No 1. Are you in good health?

Yes` No 2. Has there been any change in your general health within the past year?

3. My last physical exam was on ______________________________

Yes No 4. Are you now under the care of a physician?
If so, what is the condition being treated?
____

5. The name and address of my physician is:______________________________
____

Yes No 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem?
____

Yes No 7. Are you taking any medicine(s) including non-prescription medicine?
If so, what medicine(s) are you taking?
____
____

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

Yes No a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease

Yes No b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)

Yes No 1. Do you have chest pain upon exertion?

Yes No 2. Are you ever short of breath after mild exercise or when lying down?

Yes No 3. Do your ankles swell?

Yes No 4. Do you have inborn heart defect?

Yes No 5. Do you have a cardiac pacemaker?

Yes No c. Allergies:
Please describe: ______________________

Yes No d. Sinus trouble

Yes No e. Asthma or hay fever

Yes No f. Fainting spells, dizziness, or seizures

Yes No g. Persistant diarrhea or recent weight loss

Yes No h. Diabetes

Yes No i. Hepatitis, jaundice or liver disease

Yes No j. AIDS or HIV infection

Yes No k. Thyroid problems

Yes No l. Respiratory problems, emphysema, bronchitis, etc.

Yes No m. Arthritis or painful swollen joints

Yes No n. Stomach trouble, ulcer, colitis, or hyperacidity

Yes No o. Kidney trouble

Yes No p. Tuberculosis

Yes No q. Persistent cough or cough that produces blood

Yes No r. Persistent swollen glands in neck

Yes No s. Low blood pressure

Yes No t. Venereal disease

Yes No u. Epilepsy or other neurological disease

Yes No v. Problems with mental health

Yes No w. Cancer

Yes No x. Problems of the immune system

Yes No y. Eye disorders, glaucoma

Yes No z. Frequent headaches

Yes No 9. Have you had abnormal bleeding?

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

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

Yes No 11. Have you ever had any treatment for a tumor or growth

12. Are you allergic or have you had a reaction to:

Yes No a. Local anesthetics (novacaine)

Yes No b. Penicillin , erythromycin, or other antibiotics

Yes No c. Sulfa drugs

Yes No d. Barbiturates, sedatives, or sleeping ills

Yes No e. Aspirin

Yes No f. Codeine, demerol, or other narcotics

Yes No g. Other______________________________

Yes No 13. Have you had any serious trouble with any previous dental treatment? If so, explain:______________________________
____

Yes No 14. Do you have any disease, condition, or problem not listed above that you think I should know about? If so, please explain: ______________________________

Yes No 15. Are you wearing contact lenses?

Yes No 16. Artificial prosthetic replacements (hip, knee, pins)

Yes No 17. Are you wearing removable dental appliances?

Yes No 18. Do you smoke?

Yes No 19. Would you like your teeth whitened?

Yes No 20. Are youconcerned about your breath?

Yes No 21. Would you like to have fresher breath?

WOMEN:

Yes No 22. Are you pregnant?

Yes No 23. Are you nursing?

Yes No 24. Are you taking birth control pills?

CHIEF DENTAL COMPLAINT
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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 The Stenvall Group, or any member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

X______________________________
Signature of Patient