

Layne Martin DDS

MEDICAL HISTORY FORM

Date _____

Name _____ Home Phone () _____
Last First Middle

Address _____ Cell() _____ Business Phone () _____
Number, Street

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth ____/____/____ Sex M F Height _____ Weight _____ Single _____ Married _____
mo. day yr.

Name of Spouse _____ Closest Relative _____ Phone () _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by _____

For the following questions, 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.

- | | | |
|---|-----|----|
| 1. Are you in good health?..... | Yes | No |
| 2. Has there been any change in your general health within the past year?..... | Yes | No |
| 3. My last physical examination was on _____ | | |
| 4. Are you now under the care of a physician?..... | Yes | No |
| If so, what is the condition being treated? _____ | | |
| 5. The name and Address of my physician (s) is _____ | | |
| _____ | | |
| 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?..... | Yes | No |
| If so, what was the illness or problem? _____ | Yes | No |
| 7. Are you taking any medicine(s) including non-prescription medicine..... | Yes | No |
| If so, what medicine(s) are you taking? _____ | | |
| 8. Do you have or have you had any of the following diseases or problems? | | |
| 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 ankle swell?..... | Yes | No |
| 4. Do you have inborn heart defects?..... | Yes | No |
| 5. Do you have a cardiac pacemaker?..... | Yes | No |
| c. Allergy..... | Yes | No |
| d. Sinus trouble..... | Yes | No |
| e. Asthma or hay fever..... | Yes | No |
| f. Fainting spells or seizures..... | Yes | No |
| g. Persistent diarrhea or recent weight loss..... | Yes | No |
| h. Diabetes..... | Yes | No |
| I. Hepatitis, jaundice or liver disease..... | Yes | No |
| k. Thyroid problems..... | Yes | No |
| l. Respiration problems, emphysema, bronchitis, etc..... | Yes | No |
| m. Aids or HIV infection..... | Yes | No |
| n. Stomach ulcer 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. Sexually transmitted disease..... | Yes | No |
| u. Epilepsy or other neurological disease..... | Yes | No |
| v. Problems with mental health..... | Yes | No |
| w. Cancer..... | Yes | No |
| x. Problem on immune system..... | 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?..... Yes No
 11. Have you ever had any treatment for a tumor or growth?..... Yes No
 12. Are you allergic or have you had a reaction to:
 a. Local anesthetics..... Yes
 No
 b. Penicillin or other antibiotics..... Yes No
 c. Sulfa drugs..... Yes No
 d. Barbiturates, sedatives, or sleeping pills..... Yes No
 e. Aspirin..... Yes No
 f. Iodine..... Yes No
 g. Codeine or other narcotics..... Yes No
 h. Other _____ Yes No
 13. Have you had any serious trouble associated with any previous dental treatment?..... Yes No
 If so, explain _____ Yes No

 14. Do you have any disease, condition, or problem not listed above that you think I 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 smoke?..... Yes No
 If yes, how much? _____
 18. Do you drink alcoholic beverages?..... Yes No
 If yes, how much and what type? _____

Women

19. Are you pregnant?..... Yes No
 20. Do you have any problems associated with your menstrual period?..... Yes No
 21. Are you nursing?..... Yes No
 22. Are you taking birth control pills?..... Yes No

Chief Dental Complaint _____

Any significant dental history we should know about? _____

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 other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

 Signature of Patient