

Newton Prosthodontics Medical History Form

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Last first middle circle preferred # to confirm appointment

Home Address: \_\_\_\_\_ Zip Code \_\_\_\_\_  
number - street city - state

Work Address: \_\_\_\_\_ / \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
occupation street address city/state circle preferred # to confirm appointment

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status: S / M  
Circle one circle one

Social Security #: \_\_\_\_\_ Name of Spouse or Closest Relative: \_\_\_\_\_

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

How did you learn of this office? ( we can track our marketing or thank our referrers) \_\_\_\_\_

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?..... Y N
- 2. Has there been any change in your general health within the past year?..... Y N
- 3. My last physical examination was on \_\_\_\_\_
- 4. Are you now under the care of a physician?..... Y N  
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?..... Y N  
If so, what was the illness or problem? \_\_\_\_\_
- 7. Are you taking any medicine(s) including non-prescription medicine (ie. aspirin)..... Y N  
If so, what medicine(s) are you taking? \_\_\_\_\_
- 8. Do you have or have you had any of the following diseases or problems OR pre-medicate for your dental visits?..... Y N
  - a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease..... Y N
  - b. Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure)..... Y N
    - 1. Do you have chest pain upon exertion?..... Y N
    - 2. Are you ever short of breath after mild exercise or when lying down?..... Y N
    - 3. Do your ankles swell?..... Y N
    - 4. Do you have inborn heart defects?..... Y N
    - 5. Do you have a cardiac pacemaker?..... Y N
  - c. Allergy..... Y N
  - d. Sinus trouble..... Y N
  - e. Asthma or hay fever..... Y N
  - f. Fainting spells or seizures..... Y N
  - g. Persistent diarrhea or recurrent weight loss..... Y N
  - h. Bulimia or anorexia..... Y N
  - i. Diabetes..... Y N
  - j. Hepatitis, jaundice or liver disease..... Y N
  - k. Aids or HIV infection..... Y N
  - l. Thyroid problems..... Y N
  - m. Respiratory problems..... Y N
  - n. Arthritis or painful swollen joints..... Y N
  - o. Stomach ulcer or hyperacidity..... Y N
  - p. Kidney trouble..... Y N
  - q. Tuberculosis or persistent cough or cough that produces blood..... Y N
  - r. Persistent swollen glands in the neck region..... Y N
  - s. Low blood pressure..... Y N
  - t. Sexually transmitted disease..... Y N
  - u. Epilepsy or other neurologic disease..... Y N
  - w. Problems with mental health..... Y N
  - x. Cancer or on Chemotherapy..... Y N
  - y. Problems of the immune system..... Y N
  - z. Osteoporosis or taking medications for osteoporosis..... Y N

- 9. Have you had any abnormal bleeding?..... Y N
- 10. Have you ever required a blood transfusion?..... Y N
- 11. Do you have any blood disorder such as anemia or leukemia?..... Y N
- 12. Have you ever had any treatment for a tumor or growth?..... Y N
- 13. Are you allergic or had a reaction to:
  - a. Local anesthesia..... yes no
  - b. Penicillin or other antibiotics..... yes no
  - c. Sulfa drugs..... yes no
  - d. Barbituates, sedatives, or sleeping pills..... yes no
  - e. Aspirin..... yes no
  - f. Iodine..... yes no
  - g. Codiene or other narcotics..... yes no
  - h. Latex gloves..... yes no
  - h. Anything else not listed above \_\_\_\_\_

14. Have you had any serious trouble associated with prior dental treatment?..... Y N  
 If so, please explain \_\_\_\_\_

15. Do you have any disease, condition, or problem not listed above that you think we should know about?  
 If so, please explain \_\_\_\_\_

- 16. Are you wearing contact lenses?..... Y N
- 17. Are you wearing any dental appliances?..... Y N

**WOMEN ONLY**

- 18. Are you pregnant?..... Y N
- 19. Do you have any problems with your menstrual period or bleed heavily during menstruation (if so, good to postpone dentistry)..... Y N
- 20. Are you nursing?..... Y N
- 21. Are you taking birth control pills? (antibiotics will diminish their effect)..... Y N

WHAT IS YOUR CHIEF DENTAL CONCERN? (ie. pain, esthetics, function, etc.) \_\_\_\_\_

HAS ANYTHING PREVENTED YOU FROM ADDRESSING THIS CONCERN IN THE PAST?  
 \_\_\_\_\_

WHAT CAN WE DO TO BETER SERVE YOU THAN IN YOUR PAST DENTAL EXPERIENCES?  
 \_\_\_\_\_

WHAT ASPECT OF YOUR SMILE WOULD YOU LIKE TO CORRECT THE MOST?  
 \_\_\_\_\_

WHEN WAS YOUR LAST VISIT TO A DENTAL OFFICE AND WHAT DID YOU HAVE DONE?  
 \_\_\_\_\_

**HAVE YOU VISITED OUR WEBSITE? [www.NewtonProsthodontics.com](http://www.NewtonProsthodontics.com) ..... Y N**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I further authorize this office to verify my credit history/rating if credit terms will be extended for therapy. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions I have made in the completion of this form.

\_\_\_\_\_  
 Signature of the Patient or Guardian

\_\_\_\_\_  
 Doctor's Signature & Date

Updated & initials: \_\_\_\_\_ Updated & initials: \_\_\_\_\_

Updated & initials: \_\_\_\_\_ Updated & initials: \_\_\_\_\_