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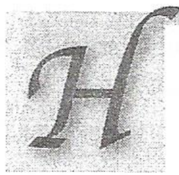

Joseph M. Hildebrand, D.D.S., P.C.
Oral and Maxillofacial Surgery

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Medical History Form

Name:______________________________ Date:______________

DOB______________________ Sex: M F Height:________ Weight:________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your health in the past year? .... Yes No
2. Are you now under the care of a physician? .... Yes No
   If so, for what condition?______________________________
3. The name, address, and phone # of my physician is:______________________________
   ____
   ____
4. Have you had a serious illness, significant operation or been hospitalized within the past 5 years? .... Yes No
5. Are you taking any medication(s)? .... Yes No
   If so, please list______________________________
   ____
6. Do you have or have you had any of the following diseases or problems?
   a. Damaged or artificial heart valves, rheumatic heart disease or heart murmur .... Yes No
   b. Heart failure, heart attack angina, high blood pressure, stroke, or any other cardiac condition .... Yes No
   c. Fainting spells, seizures, epilepsy, or neurological disorder .... Yes No
   d. Diabetes or thyroid problems .... Yes No
   e. Hepatitis, jaundice or liver disease .... Yes No
   f. Respiratory problems, asthma, emphysema, bronchitis or chronic cough .... Yes No
   g. Arthritis or painful swollen joints including your jaw joint (TMJ) .... Yes No
   h. Stomach ulcer or reflux .... Yes No
   i. Kidney trouble .... Yes No
   j. Tuberculosis .... Yes No
   k. Are you taking vitamins, homeopathic remedies, or diet pills .... Yes No
7. Have you had abnormal bleeding or been diagnosed with any type of anemia? .... Yes No
   a. Have you ever required a blood transfusion? .... Yes No
8. Are you allergic to or have you had a reaction to:
   a. Local anesthetics .... Yes No
   b. Penicillin, sulfa drugs or other antibiotics .... Yes No
   c. Aspirin .... Yes No
   d. Iodine .... Yes No
   e. Codeine or other narcotics .... Yes No
   f. Latex or rubber products .... Yes No
   g. Other Medications .... Yes No
9. Have you had any serious trouble associated with previous dental treatment? .... Yes No
   If so, explain:______________________________
10. Do you smoke? .... Yes No
    If so, how much?______________________________

11. Do you have any other conditions or disease you think the doctor should know about? .... Yes No
If so, explain____
____
12. Are you wearing contact lenses? .... Yes No
13. Are you wearing removable dental appliances? .... Yes No
14. Do you wish to talk with the doctor privately about anything? .... Yes No

Women

15. Are you pregnant or trying to become pregnant? .... Yes No
16. Are you nursing? .... Yes No
17. Are you taking birth control pills? .... Yes No

Chief Dental Complaint or Purpose of Consultation: ______________________________
____
____

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 member of the staff responsible for any errors or omissions that I may have made in the completion of the form.

Date:______________________ Patient's Signature: ______________________________

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: ______________________________
____
____
____

Significant findings from questionnaire or oral interview: ______________________________
____
____
____

Dental management considerations/risks: ______________________________
____
____
____

Date:______________________ Doctor's Signature: ______________________________