Windy City Smiles

www.windycitysmiles.com

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Medical & Dental History Form

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ____ ____________________
Last First MI Preferred Name

Title: __________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ______________________________ **Best time to call:** ____________________

Phone: __________ __________ __________ ______ __________ __________
Home Mobile Work Ext Fax Other

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ________ _____-____
City State Zip Code

Occupation

____

____

Height, & Weight

____

____

Emergency contact (Name & Phone number)

____

____

Referred by:

____

____

Please take a moment to let us know about your history so we may serve you more effectively. During your initial visit you will be asked some question about your responses and there may be additional questions concerning your health.

1. Would you consider yourself to be in good health? ◯ Yes ◯ No

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

3. What is the date (or approximate date) of your last medical exam?

____

____

4. Are you now under the care of a physician? ◯ Yes ◯ No

If yes, what is the condition being treated?

____

____

____

5. Your Primary Care Physician's name, address, & phone number:

____

____

____

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6. Have you had any serious illness, operation. or been hospitalized in the past 5 years? ◯ Yes ◯ No

If yes, what was the illness or problem?

____

____

7. Are you taking any medicine(s) including non-prescription medicine? ◯ Yes ◯ No

If yes, what medicine(s) are you taking?

____

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____

Please indicate if you have experienced any of the following diseases or problems:

☐ *Pre-Med	☐ Allergies	☐ Allergy, Asprin	☐ Allergy, Codeine
☐ Allergy, Latex	☐ Allergy, Penicillin	☐ Allergy, Sulfa	☐ Anemia
☐ Arthritis	☐ Artificial Heart Val	☐ Artificial Joints	☐ Asthma or Hay fever
☐ Blood Disease	☐ Bronnchitis	☐ Cancer	☐ Coumidin Treatment
☐ Diabetes	☐ Dizziness	☐ Emphysema	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Fainting Spells	☐ Glaucoma
☐ Growths	☐ HIV or AIDS	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ Immune Sys. Disorder
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Mental Disorders	☐ Nervous Disorders	☐ Neurological Desease	☐ Pacemaker
☐ Persistent Diarrhea	☐ Persistent cough	☐ Pregnancy	☐ Radiation Treatment
☐ Recent weight loss	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ S.T.D.'s	☐ Seizures	☐ Sinus Problems	☐ Stomach Problems
☐ Stomach Ulcers	☐ Stroke	☐ Swollen joints	☐ Swollen neck glands
☐ Thyroid Problems	☐ Tuberculosis	☐ Tumors	☐ Venereal Disease

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

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

8 b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke).
◯ Yes ◯ No

8 b1. Do you have chest pain upon exertion? ◯ Yes ◯ No

8 b2. Are you ever short of breath after mild exercise or when lying down? ◯ Yes ◯ No

8 b3. Do your ankles swell? ◯ Yes ◯ No

8 b4. Do you have inborn heart defects? ◯ Yes ◯ No

9. Have you had abnormal bleeding? ◯ Yes ◯ No

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

10. Have you ever had any treatment for a tumor or growth? ◯ Yes ◯ No

11. Are you allergic or have you had a reaction to the following:

11 a. Local anesthetics ◯ Yes ◯ No

11 b. Penicillin or other antibiotics ◯ Yes ◯ No

11 c. Barbituates, sedatives, or sleeping pills ◯ Yes ◯ No

11 d. Iodine ◯ Yes ◯ No

11 e. Codeine or other narcotics ◯ Yes ◯ No

11 f. Other

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12. Do you have any disease, condition, or problem not listed above that you think I should know about? If yes, please explian

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13. Are you wearing contact lenses? ◯ Yes ◯ No

14. What is the date (or approximate date) of your last dental exam?

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15. Have you had any serious trouble associated with any previous dental treatment? If yes, please explian

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16. Are you wearing removable dental appliances? ◯ Yes ◯ No

17. What is the reason for your dental visit today?

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WOMEN ONLY:

18. Are you pregnant? ◯ Yes ◯ No

19. Do you have any problems associated with your menstrual period? ◯ Yes ◯ No

20. Are you nursing? ◯ Yes ◯ No

21. Are you taking birth control pills? ◯ Yes ◯ No

Authorization

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.
I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. Such information may be used in research, education, publication in professional journals, and or for any other use you deem appropriate

Signature of patient, parent, or guardian:

Signature ______________________________ **Date** __________

Relationship to Patient:

____

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Response Date: __________