Newton Wellesley Dental Partners - Medical History Form

Today's Date: _____

Name:_____ **Home Phone:( )**_____
Last first middle circle preferred # to confirm appointment

Home Address:_____ **Cell Phone: ( )** _____
circle preferred # to confirm appointment

Work Address:_____/_____ **Work Phone: ( )**_____
occupation street address city/state/zip circle preferred # to confirm appointment

Email Address *(would you prefer to have your appointments confirmed via email? Yes No):*_____

Date of Birth:_____/_____/_____ **Sex: M / F** (Circle one) **Height:**_____ **Weight:**_____ **Marital Status: S / M** (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? (so 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 (please circle answer):

AIDS/HIV	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint (s)	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Diarrhea	Yes No	Kidney Problems	Yes No	Spinal Bifida	Yes No
Blood Transfusion	Yes No	Frequent Headaches	Yes No	Leukemia	Yes No	Stomach/Intestinal Issues	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No

Have you ever had any serious illness not listed above...Please explain below. Explain '*Yes*' answers below.

_____

_____

_____

PLEASE CONTINUE ON THE OTHER SIDE or ON PAGE 2

Patient Name:_____ ***Date***:_____

9. Have you had any abnormal bleeding?..... Y N
10. Have you ever required a blood transfusion?..... Y N
11. Have you ever had any treatment for a tumor or growth?..... Y N
12. 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_____
13. Have you had any serious trouble associated with prior dental treatment?..... Y N

    If so, please explain_____
    _____
14. 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 BETTER 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.NewtonWellesleyDentalPartners.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:_____