Medical History Form

Dr. Gary Login
209 Harvard Street,
Brookline, MA 02446

Fax: 617-566-5331
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grlogin@yahoo.com

Current Date 12/19/11

Name (Last, First, M) | Home Phone

Street Address | Bus. Phone

City, St, Zip | Cell Phone

Social Security Number | Email

Occupation | Employer/Address

Date of Birth | ☐ Female ☐ Male | Marital Status Single | Height | Weight

Name of Spouse | Closest Relative | Phone

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

Referred by:

Insurance Company | Policy Number

Are you in good health? ◯ Yes ◯ No Last Physical Exam

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

Are you now under the care of a physician? If so, what condition? ◯ Yes ◯ No

Physician Name | Physician Address

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

Please list all medications
(prescription and non prescription)

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

A. Damaged or artificial heart valves, including murmur or rheumatic heart disease. . . . . ☐ Yes ☐ No

B. Cardiovascular disease (heart trouble, heart attach, angina, coronary insufficiency, coronary, occlusion, high blood pressure, arteriosclerosis, stroke) ☐ Yes ☐ No

1. Do you have chest pain exertion? . . . . . ☐ Yes ☐ No
2. Are you ever short of breath after midl exercise or lying down? . . . . . ☐ Yes ☐ No
3. Do your ankles 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	☐ Yes	☐ No	G. Seizures	☐ Yes	☐ No	H. Persistent Diarrhea	☐ Yes	☐ No
I. Hepatitis	☐ Yes	☐ No	J. Jaundice	☐ Yes	☐ No	K. Diabetes (or relative with)	☐ Yes	☐ No
L. Liver Disease	☐ Yes	☐ No	M. Thyroid Problem	☐ Yes	☐ No	N. AIDS or HIV infection	☐ Yes	☐ No
O. Kidney trouble	☐ Yes	☐ No	P. Tuberculosis	☐ Yes	☐ No	Q. Respiratory problems	☐ Yes	☐ No
R. Stomach Ulcer	☐ Yes	☐ No	S. Arthritis or painful swollen joints; hip, knee, or joint replacement				☐ Yes	☐ No
T. Low Blood Pressure	☐ Yes	☐ No	U. Sexually Transmitted disease				☐ Yes	☐ No
V. Mental Health Problem	☐ Yes	☐ No	W. Epilepsy or other neurological disease				☐ Yes	☐ No
X. Cancer	☐ Yes	☐ No	Y. Problems with immune system				☐ Yes	☐ No

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Persistent cough or cough that produces blood ☐ Yes ☐ No
Persistent swollen glands in the neck? ☐ Yes ☐ No
Have you had abnormal bleeding? ☐ Yes ☐ No
Have you ever required a blood transfusion? ☐ Yes ☐ No
Do you have a blood disorder, such as anemia ☐ Yes ☐ No
Have you had treatment for a tumor or growth ☐ Yes ☐ No

Are you allergic or have any reaction to:

Local Anesthetics	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No	other antibiotics	☐ Yes ☐ No
Sulfa drugs	☐ Yes ☐ No	Barbiturates	☐ Yes ☐ No	Sedatives or sleeping pills	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Iodine	☐ Yes ☐ No	Codeine or other narcotics	☐ Yes ☐ No

Other

Have you had any serious trouble associated with any previous dental treatment, Explain

Do you have any disease, condition, or problem not listed above that you think I should know about?

Are you wearing contact lenses? ☐ Yes ☐ No
Are you wearing removable dental appliances? ☐ Yes ☐ No

Do you use tobacco products, If yes, how much??

Women

Are you pregnant? ☐ Yes ☐ No
Do you have any problems associated with your menstrual period? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Chief Dental Complaint?

☐ I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires 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.

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