Main Street Dental Arts,PC
516 W. Main St.
Waxahachie, TX 75165
Telephone 972-937-1841

MEDICAL HISTORY FORM

Patient

Name _____Home Phone_____
Address_____Work Phone_____
City_____State_____Zip Code_____
Email Address_____ Cell Phone_____
Employer_____ Social Security Number_____
Date of Birth_____Age_____ Sex M F Height_____Weight_____
Single__Widowed__Divorced___Married___ Drivers License_____

Responsible Party or Spouse

Name _____Home Phone_____
Address_____Work Phone_____
City_____State_____Zip Code_____
Email Address_____ Cell Phone_____
Employer_____ Social Security Number_____
Date of Birth_____ Drivers License_____

Emergency Contact_____Phone_____
How did you hear about our office?_____

For the following questions, circle yes or no. Your answers will be considered confidential.

Are you in good health?..... Yes No
Has there been any changes in your health since last year?..... Yes No
My last physical exam was on_____
Are you under the care of a physician?..... Yes No
If so, for what condition?_____
The name and address of my physician is: _____
_____
_____
Have you had any serious illness, operation or hospitalization within the past 5 years?..... Yes No
If so, please list_____
_____
Please list any medicine(s), including non-prescription drugs, vitamins, and recreational drugs:
_____
_____

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

a. Damaged heart valves, artificial valves or murmur**, or artificial joint**	**Yes**	**No**
b. Rheumatic Heart Disease	**Yes**	**No**
c. Heart trouble, heart attack, angina, **high blood pressure**, stroke, arteriosclerosis or any other heart condition(please circle the ones that apply)	**Yes**	No
1. Chest pain on exertion?	Yes	No
2. Shortness of breath after mild exercise?	Yes	No
d. General Allergies or sinus trouble	Yes	No
e. Asthma	Yes	No
f. Fainting spells or seizures	Yes	No
g. Diabetes	**Yes**	**No**
h Hepatitis, jaundice or liver disease	Yes	No
i. Frequent or recurring mouth sores	Yes	No
j. Thyroid problems	Yes	No
k. Respiratory problems, emphysema, bronchitis, etc	Yes	No
l. Stomach ulcer or hyperacidity	Yes	No
m. Kidney trouble	Yes	No
n. Problems with mental health	Yes	No
o. Radiation Treatment to head or neck	Yes	No
p. Problems of the immune system	Yes	No
q. Ear problems or tubes in your ears?	Yes	No
r. Abnormal bleeding?	Yes	No
s. Blood transfusion?	Yes	No
t. Blood disorder such as anemia?	Yes	No
u. Attention Deficit Disorder or are you on Ritalin?	Yes	No
v. Glaucoma?	Yes	No
w. Are you taking bloodthinners?	**Yes**	**No**

Are you allergic or have you had a reaction to:

a. Local anesthetics	**Yes**	**No**
b. Penicillin or antibiotics	**Yes**	**No**
c. Sulfa drugs	**Yes**	**No**
d. Barbiturates or sleeping pills	**Yes**	**No**
e. Aspirin	**Yes**	**No**
f. Iodine	**Yes**	**No**
g. Codeine or other narcotics	**Yes**	**No**
h. Latex	**Yes**	**No**
i. Nickel, chromium, or any other metals?	**Yes**	**No**
j. Other	Yes	No
Have you had any serious trouble associated with previous dental?	Yes	No

If so, explain_____

_____

Do you smoke, dip, chew, wear a nicotine patch or chew nicotine gum? Yes No

Women:

Are you pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control pills?	Yes	No

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 this form.

Patient/Guardian _____ Date _____