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

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 _____