**Jonathan F. Powell, D.D.S.**

**MEDICAL HISTORY FORM**

Name: Date:

Date of Birth: Sex: M / F Height: Weight:

---

**For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.**

1. Are you in good health? Yes No
2. Has there been any change in your health in the past year? Yes No
3. My last physical exam was on / /
4. Are you now under the care of a physician? Yes No
   If so, for what condition?
5. The name and address of my physician is:

6. Have you had any serious illness, significant operation or hospitalization within the past 5 years? Yes No
7. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur 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**) Yes No
      1. Chest pain upon exertion? Yes No
      2. Shortness of breath after mild exercise? Yes No
      3. Do your ankles swell? Yes No
   d. Artificial joint replacement Yes No
   e. Sinus trouble Yes No
   f. Asthma or hay fever Yes No
   g. Fainting spells or seizures Yes No
   h. Diabetes Yes No
   i. Hepatitis, jaundice or liver disease Yes No
   j. Frequent or recurring mouth sores Yes No
   k. Thyroid problems Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes No
   n. Stomach ulcer or hyperacidity Yes No
   o. Kidney trouble Yes No
   p. Tuberculosis Yes No
   q. Persistent cough or cough that produces blood Yes No
   r. Persistent swollen neck glands Yes No
   s. Low blood pressure Yes No
   t. Epilepsy or neurological disorder Yes No
   u. Are you taking vitamins or homeopathic remedies Yes No
   v. Cancer Yes No
   w. Any disease, drug or transplant operation that has depressed your immune system Yes No
   x. Pacemaker Yes No
   y. Psychiatric disorders Yes No
   z. HIV+/AIDS Yes No
8. Have you had abnormal bleeding? Yes No
   a. Have you ever required a blood transfusion? Yes No
9. Do you have any blood disorder such as anemia? Yes No
10. Have you ever had treatment for a tumor or growth? Yes No
11. Are you allergic to 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

**Jonathan F. Powell, D.D.S.**

h. Latex or rubber products Yes No
i. Other Yes No
12. Do you use tobacco products? Yes No
13. Have you had any serious trouble associated with previous dental treatment? Yes No
If so, explain:

14. Do you have any other condition or disease you think the doctor should know about? Yes No
If so, explain:
15. Do you wish to talk with the doctor privately about anything? Yes No

No

**Women**
16. Are you pregnant or trying to become pregnant Yes No
17. Are you nursing? Yes No
18. Are you taking birth control pills? Yes No

**Chief Dental Complaint:**

**Please list all medications you are taking:**

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

**Please list all allergies to medications:**

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

**Please provide the name, address, and telephone information of the person to contact in the event of an emergency.**

Name: _____ Telephone: (_____)_____
Address: _____

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.

Date: Patient's Signature:

Date: Doctor's Signature:

Medical History Update:

Date Comments Signature