Golden Dental Wellness Center
A HEALTHY SMILE IS GOLDEN

MEDICAL HISTORY FORM

444 Community Dr. Suite 204, 11030 Manhasset, N.Y.
Phone: (516) 627-8400 • **Fax:** (516) 627-9047
E-mail: goldendental@optonline.net

Date _____

Name _____ **Home Phone** (____) _____

Address _____ **Business Phone** (____) _____

City _____ **State** _____ **Zip Code** _____

E-Mail Address _____ **Cell Phone** (____) _____

Occupation _____ **Social Security No.** _____

Date of Birth ___ / ___ / ___ (mo. / day / yr.) **Sex** M F **Height** _____ **Weight** _____ **Single** _____ **Married** _____ **Domestic Partner** _____

Name of Spouse _____ **Closest Relative** _____ **Phone** (____) _____

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

Whom May We Thank For Referring You? _____

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?** ..... **Yes No**
2. **Has there been any change in your general health within the past year?** ..... **Yes No**
3. **My last physical examination was on:** _____
4. **Are you now under the care of a physician or naturopath?** ..... **Yes No**
   If so, what is the condition being treated? _____
5. **The name and address of my physician(s) and/or naturopath is:** _____
   _____ **Phone #:** _____
6. **Have you had any serious illness, operation, or been hospitalized in the past 5 years?** ..... **Yes No**
   If so, what was the illness or problem? _____
7. **Are you taking any medicine(s) including non-prescription medicine?** ..... **Yes No**
   If so, what medicine(s) are you taking? _____
8. **Do you have or have you had any of the following diseases or problems?**

a. Damaged heart valves, including heart murmur, Mitro-Valve Prolapse (MVP), or rheumatic disease ..... **Yes No**

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... **Yes No**

- **1. Do you have chest pain upon exertion?** ..... **Yes No**
- **2. Are you ever short of breath after mild exercise or when 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. Have you had a hip replacement or any metal rods, pins, or implants? ..... **Yes No**

d. Do you need to Pre-Medicate for your dental treatment? ..... **Yes No**

If yes, reason why: _____

e. Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No
f. Seasonal Allergies Yes No
g. Sinus trouble Yes No
h. Asthma or hay fever Yes No
i. Fainting spells or seizures Yes No
j. Persistent diarrhea or recent weight loss Yes No
k. Diabetes Yes No
l. Hepatitis, jaundice or liver disease Yes No
m. Problems of the immune system Yes No
n. Sexually transmitted disease Yes No
o. AIDS or HIV infection Yes No
p. Thyroid problems Yes No
q. Respiratory problems, emphysema, bronchitis, etc Yes No
Do you smoke any form of tobacco Yes No
r. Arthritis or painful swollen joints Yes No
s. Stomach ulcer or hyperacidity Yes No
t. Kidney trouble Yes No
u. Tuberculosis Yes No
1. Do you have a heavy, persistent cough of 2-3 weeks duration, particularly one that bring up sputum or bloodied sputum? Yes No
2. Do you wake up multiple times at night to change your clothes and bedding because they are unusually saturated with perspiration? Yes No
v. Persistent swollen glands in neck Yes No
w. Low blood pressure Yes No
x. Epilepsy or other neurological disease Yes No
y. Problems with mental health Yes No
z. Cancer Yes No
9. Have you had abnormal bleeding? Yes No
a. Have you ever required a blood transfusion? Yes No
10. Do you have any blood disorder such as anemia? Yes No
11. Have you ever had any treatment for a tumor or growth? Yes No
12. Are you allergic or have you had a reaction to:
a. Local anesthetics Yes No
b. Penicillin or other antibiotics Yes No
c. Sulfa drugs Yes No
d. Barbiturates, sedatives, or sleeping pills Yes No
e. Aspirin Yes No
f. Iodine Yes No
g. Codeine or other narcotics Yes No
h. Latex Yes No
1. Are you allergic to or unable to eat bananas, avocados, chestnuts, kiwis, potatoes, hazelnuts, or tomatoes? Yes No

2. Do you have history of surgery, especially, several repeated procedures in childhood? Yes No
3. Do you have Spina Bifida? Yes No
4. Repeated urinary catherization? Yes No
5. Can you blow up balloons? Yes No

i. Other _____

13. Have you had any serious trouble associated with any previous dental treatment? Yes No
If so, explain _____

_____

14. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No
If so, explain _____

_____

15. Are you wearing contact lenses? Yes No
16. Are you wearing removable dental appliances? Yes No
17. How many times a week do you floss? _____ a day do you brush? _____
18. What type of bristles do you use? ____ soft ____ medium ____ hard ____ don't know
19. Do You suffer from any sleeping such as Sleep apnea? Yes No
20. Do you get neck pain? Yes No
21. Do you have difficulty breathing from your nose? Yes No
22. Do you have restless sleep? Yes No

Why have you come to the dentist today? _____

_____

Children:

19. ADD/ADHD Yes No
20. Allergies Yes No
21. Upper respiratory infections Yes No
22. Ear infections Yes No
23. Ear Tubes Yes No
24. Bed Wetting Yes No
25. Nightmares/ Night Terrors Yes No
26. Poor Academic performance Yes No
27. Clenching/ Grinding Teeth Yes No
28. small/ delayed growth Yes No
29. Anxiety Yes No
30. Depression Yes No
31. Daytime Sleepiness Yes No
32. under eye blueness or puffy Yes No
33. Night Sweats Yes No
34. GI Distress Yes No
35. Emotional Instability Yes No
36. Sensory issues Yes No
37. Restless Sleep Yes No

Women:

38. Are you pregnant? ..... Yes No
39. Do you have any problems associated with you menstrual period? ..... Yes No
40. Are you nursing? ..... Yes No
41. Are you taking birth control pills? ..... Yes No

FAMILY HISTORY:

42. Please list any serious medical conditions your parents may have? _____

43. Do either of your parents have periodontal disease? _____

44. Does heart disease AND/OR diabetes run in your family? ..... Yes No
    a-If YES, what is their relation to you? _____

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 other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient/Parent or Guardian

Person Responsible for Account: _____ _____
Print Name Signature

For completion by the dentist:

Comments on patient interview concerning medical history: _____

Significant findings from questions from questionnaire or oral interview: _____

Dental management considerations: _____

_____ _____
(Date) Signature of Dentist