North Country Family Health Center, Inc.

DENTAL SERVICES

Patient Medical History

Name	Date of Birth	Today's Date

The following conditions require medical clearance from your doctor BEFORE your appointment:
HIP OR KNEE REPLACEMENT, PREGNANCY, HEART ATTACK OR STROKE WITHIN THE LAST 6 MONTHS.

Heart and Circulatory Problems

	Yes	No	?
1) Damaged Heart Valve			
2) Artificial Heart Valve			
3) Heart Murmur			
4) Rheumatic Heart Disease			
5) Heart Disease			
6) Heart Trouble			
7) Cardiac Pacemaker			

	Yes	No	?
9) Heart Attack			
10) Angina			
11) High Blood Pressure			
12) Low Blood Pressure			
13) Inborn Heart Defects			
14) Stroke			
15) Chest Pain on Exertion			

	Yes	No	?
16) Shortness of Breath with mild exercise or when lying down			
17) Swollen Ankles			
18) Other:			

Liver Problems

	Yes	No	?
1) Hepatitis			
2) Jaundice			
3) Liver Disease			

Muscle and Joint Problems

	Yes	No	?
1) Hip/Knee Replacement			
2) Painful Swollen Joints			
3) Arthritis			

Blood

	Yes	No	?
1) Anemia			
2) Blood Disorder			

Breathing and Lung Problems

	Yes	No	?
1) Asthma			
2) Respiratory Problems			
3) Emphysema			
4) Bronchitis			

	Yes	No	?
5) Tuberculosis			
6) Persistent Cough			
7) Cough Producing Blood			

Stomach Problems

	Yes	No	?
1) Persistent Diarrhea			
2) Recent Weight Loss			
3) Stomach Ulcer			
4) Gastric Reflux			

Other

	Yes	No	?
1) Diabetes			
2) AIDS			
3) HIV Infection			
4) Thyroid Problems			
5) Persistent Swollen Neck Glands			
6) Are you Pregnant?			

	Yes	No	?
7) Mental Health Problems			
8) Kidney Trouble			
9) Immune System Problems			
10) Cancer			
11) Sexually Transmitted Disease			
What type of Birth Control do you use?			

Neurological

	Yes	No	?
1) Fainting Spells			
2) Seizures			
3) ADHD			
4) Autism			

Current Allergies

	Yes	No	?
1) Latex			
2) Local Anesthetics			
3) Penicillin			
4) Other Antibiotics			

	Yes	No	?
5) Sulfa Drugs			
6) Barbiturates			
7) Sedatives			
8) Sleeping Pills			

	Yes	No	?
9) Aspirin			
10) Iodine			
11) Codeine			
12) Other:			

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Current Medications

Past Medical History

	Yes	*No*	*?*
Have you ever had any treatment for a tumor or growth?	◯	◯	
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	◯	◯	
If so, what was the illness or problem?			

History Update

Date _____ Comments _____

Signature: _____

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