



Medical History Form

Patient Name: _____ Emergency Contact _____
Date of Birth: _____ Emergency Contact Phone _____
Sex: _____ Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis	Yes	No
Persistent cough greater than a 3 week duration	Yes	No
Cough that produces blood	Yes	No
Been exposed to anyone with tuberculosis	Yes	No

Medical History

Are you now under the care of a physician? Yes No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? Yes No

Has there been any change in your general health within the past year? Yes No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

Do you wear contact lenses? Yes No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics	Yes	No	Latex (rubber)	Yes	No
Aspirin	Yes	No	Iodine	Yes	No
Penicillin or other antibiotics	Yes	No	Hay fever/seasonal	Yes	No
Barbiturates, sedatives, or sleeping pills ...	Yes	No	Animals	Yes	No
Sulfa drugs	Yes	No	Food	Yes	No
Codeine or other narcotics	Yes	No	Other	Yes	No
Metals	Yes	No	If Other, please specify: _____		

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve	Yes	No	Unrepaired, cyanotic CHD	Yes	No
Previous infective endocarditis	Yes	No	Repaired (completely) in the last 6 months	Yes	No
Damaged valves in transplanted heart	Yes	No	Repaired CHD with residual defects	Yes	No
Congenital heart disease (CHD)	Yes	No			

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease	Yes	No	Rheumatic heart disease	Yes	No
Angina	Yes	No	Abnormal bleeding	Yes	No
Arteriosclerosis	Yes	No	Anemia	Yes	No
Congestive heart failure	Yes	No	Blood transfusion	Yes	No
Damaged heart valves	Yes	No	If yes, date		
Heart attack	Yes	No	Hemophilia	Yes	No
Heart murmur	Yes	No	AIDS or HIV	Yes	No
Low blood pressure	Yes	No	Arthritis	Yes	No
High blood pressure	Yes	No	Autoimmune disease	Yes	No
Other congenital heart defects	Yes	No	Rheumatoid arthritis	Yes	No
Mitral valve prolapse	Yes	No	Systemic lupus erythematosus	Yes	No
Pacemaker	Yes	No	Asthma	Yes	No
Rheumatic fever	Yes	No	Bronchitis	Yes	No
Emphysema	Yes	No	Fainting spells or seizures	Yes	No
Sinus trouble	Yes	No	Neurological disorders	Yes	No
Tuberculosis	Yes	No	If yes, please specify		
Cancer/Chemotherapy/Radiation Treatment	Yes	No	Sleep disorder	Yes	No
Chest pain upon exertion	Yes	No	Mental health disorders	Yes	No
Chronic pain	Yes	No	Specify		
Diabetes Type I or II	Yes	No	Recurrent infections	Yes	No
Eating disorder	Yes	No	Type of infection		
Malnutrition	Yes	No	Kidney problems	Yes	No
Gastrointestinal disease	Yes	No	Night sweats	Yes	No
G.E. Reflux/persistent heartburn	Yes	No	Osteoporosis	Yes	No
Thyroid problems	Yes	No	Persistent swollen glands in neck	Yes	No
Stroke	Yes	No	Severe headaches/migraines	Yes	No
Glaucoma	Yes	No	Severe or rapid weight loss	Yes	No
Hepatitis, jaundice or liver disease	Yes	No	Sexually transmitted disease	Yes	No
Epilepsy	Yes	No	Excessive urination	Yes	No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

Please explain _____

Signature of Patient/Legal Guardian

BREATHE WELL SLEEP SOLUTIONS

Prenatal/Postnatal Questions

Were there any complications during pregnancy? _____

How many weeks old was your child delivered? _____

Were there any complications during birth? _____

Was your child delivered vaginally or surgically? _____

Was your child ever diagnosed/treated with a tethered tongue/tongue tie? _____

What symptoms prompted the diagnosis/treatment? _____

Was there any relief of symptoms after the procedure? _____

How long was your child able to breastfeed? _____

Did your child use a pacifier regularly after 6 months of age? _____

If so, what was the duration of use? _____

Did your child suck on their thumb? _____

If so, what was the duration of use? _____

Does your child have a history of nasal congestion prohibiting nasal breathing? _____

Did your child have difficulties with speech? _____

If so, was a speech therapist utilized? _____

Did your child have difficulties with any other neurological/growth milestone? _____

If so, please describe. _____