Donald L. Theriault, D.M.D. Office: 207-774-1471 595 Brighton Ave, Portland ME 04102

DATE ___________________________

MEDICAL HISTORY FORM

Name ____Phone _______________________________
Date of Birth ______________ Sex F M Height _________ Weight ____________aaa
Name of Spouse ___________________________
If you are completing this form for another person, what is your relationship to that person? _______________

Referred by ____

For the following questions, circle yes or no. Your answers are for our records only and will be kept strictly 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? If so, what is the condition being treated YES NO

____

5. The name and address of my physician(s)

6 Do you smoke? YES NO
7 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?

8. Are you taking any medicine(s) including non-prescription medicine ? YES NO
If so, what medicine(s) are you taking?

Updates:

9. Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? YES NO

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion 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 high blood pressure? YES NO

c. Allergies ____

10. Have you had abnormal bleeding? YES NO
    a. Have you ever required a blood transfusion? YES NO
11. Do you have any blood disorder such as anemia? YES NO
12. Have you ever had treatment for a tumor or growth? YES NO
13. 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. Other ____
14. Have you had any serious trouble associated with any previous dental treatment? YES NO
    If so, explain ____
15. Do you have any disease, condition, or problem not listed above that you think I should know about?
    If so, explain ____
16. Are you wearing contact lenses? YES NO
17. Are you wearing removable dental appliances YES NO

WOMEN

18. Are you pregnant or nursing? YES NO
19. Are you taking birth control pills? YES NO

CHIEF REASON FOR COMING

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 no hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have make in the completion of this form.

Signature of Patient ____

Date ____________________ Signature of Dentist ______________________________

Remarks/Updates.