

Goma Dental - Medical History

patient's name: _____
last
first
initial
date of birth

Please circle the appropriate answer.
 If you don't know the correct answer please write "don't know" on the line after the question.

1. Physician's name _____
 Address _____
2. Are you under a physician's care? yes no
 Since when? _____ Why? _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? yes no
 (if yes please list medications in the lines provided at the bottom of page)
5. Are you allergic to any medication or substances? yes no
 If yes, please list: _____
6. Do you have any problems with penicillin, antibiotics, anesthetics or any
 other medications? yes no
7. Are you sensitive to metals or latex? yes no
8. Are you pregnant or suspect you may be? yes no
9. Do you use any birth control medications? yes no
10. Have you ever been treated for or been told you might have heart disease?..... yes no
11. Do you have a pacemaker or an artificial heart valve implant? yes no
12. Have you ever had rheumatic fever? yes no
13. Are you aware of any heart murmurs? yes no
14. Do you have high or low blood pressure? yes no
15. Have you ever had a serious illness or major surgery? yes no
 If so, explain _____
16. Have you ever had radiation or chemotherapy treatment? yes no
17. Do you have inflammatory diseases, such as arthritis or rheumatism? yes no
18. Do you have any artificial joints/prosthesis? yes no
19. Do you have any blood disorders, such as anemia, leukemia, etc.? yes no
20. Have you ever bled excessively after being cut or injured? yes no
21. Do you have any stomach, kidney or liver problems?..... yes no
22. Are you diabetic? yes no
23. Do you have asthma? yes no
24. Do you have epilepsy or seizure disorders? yes no
25. Have you ever tested HIV positive? yes no
26. Do you have AIDS? yes no
27. Have you ever tested positive for hepatitis? yes no
28. Do you or have you ever had tuberculosis?..... yes no
29. Have you ever smoked, chewed, used snuff or any other form of tobacco? yes no
 Number of years of used? _____ Number of years quit? _____
30. Do you have any disease, condition, or problem not listed? yes no
 If so, explain _____
31. Is there anything else we should know about your health that we have not
 covered in this form? _____
32. Would you like to speak to the doctor privately about any problem? yes no

Please list any medications/substances you are currently taking on the lines provided below:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

DENTIST'S SIGNATURE: _____ **DATE:** _____