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It is our goal at Strom, Klein & Associates to provide you with the most comprehensive care possible. Please take a minute and fill out this thorough medical history form.
Thank you!

Name: _____ Date: _____
I prefer to be called: _____ Male Female

DOB: _____ Age: _____ SS#: _____

Home Address: _____
Home phone: _____ Work phone: _____
Mobile phone: _____ Preferred method of contact: _____

Employer: _____
Adress: _____
Occupation: _____ How long there? _____

Who can we thank for referring you to us? _____

Dental Insurance Information:

Primary Dental Insurance: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Insured's Name: _____ Relation: _____

Group #: _____ Insured's Birthdate: _____

Insured's SS#: _____ Insured's Employer: _____

Secondary Dental Insurance: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Insured's Name: _____ Relation: _____

Group #: _____ Insured's Birthdate: _____

Insured's SS#: _____ Insured's Employer: _____

Emergency Contact:

In the event of an emergency who may we contact? _____

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Relation: _____
Phone number: _____

I. Please circle the appropriate answer (Leave blank if you do not understand the question)

1) Yes / No Is your general health good?
If NO, please explain: _____
_____

2) Yes / No Has there been a change in your health in the last year?
If YES, please explain: _____
_____

3) Yes / No Have you gone to the Hospital, Emergency Room, or had a serious illness in the last three (3) years?
If YES, please explain: _____
_____

4) Yes / No Are you currently being treated by a physician?
If YES, please explain: _____
Date of last medical exam: _____
Name of Physician: _____
Phone number of physician: _____

5) Yes / No Are you taking any kind of medication? (including prescription & supplements)
Please List: _____
_____
_____

II. DENTAL HISTORY

1) When was your last dental visit? _____

2) Yes / No Have you had any problems with dental treatment in the past?
Please explain:
_____
_____

3) Yes / No Are you in pain now?
If YES, please explain: _____
_____

4) Yes / No Do you have dental anxiety?
If YES, please rate your level of anxiety (circle one):
Very High High Medium Low

What makes you most anxious? _____
_____

5) What is the primary reason for your visit today? _____
_____

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6) Are you interested in: ___Whitening ___Straightening your teeth
___Sedation ___Sleep apnea treatment ___Veneers
___Same day crowns

III. CARDIOVASCULAR HEALTH:
Do you have/had:

1) Y N … High Blood Pressure
2) Y N … Heart Murmur/rheumatic heart disease
3) Y N … Damaged/Artificial heart valves
4) Y N … Chest pain during physical exertion
5) Y N … Chest pain when lying down
6) Y N … Difficulty breathing when lying down
7) Y N … Swollen ankles
8) Y N … Congenital Heart disease
9) Y N … Heart attack
10)Y N … Angina
11) Y N … Coronary Artery Disease
12) Y N … Pacemaker
13) Y N … Heart Surgery (please specify) _____

IV. RESPIRATORY HEALTH: Do you have/had:

1) Y N … Asthma
2) Y N … Tuberculosis
3) Y N … Pneumonia
4) Y N … Bronchitis
5) Y N … Coughed up blood
6) Y N … Persistent cough for > 3 months
7) Y N … Emphysema
8) Y N … Sinus problems

V. NEUROMUSCULAR: Do you have/had:

1) Y N …Fainting spells/dizziness
2) Y N …Seizures/epilepsy
3) Y N …Numbness/tingling/paralysis
4) Y N …Muscle weakness/Multiple Sclerosis
5) Y N …Recurrent/chronic back/neck aches
6) Y N …Problems with walking/balance
7) Y N …Painful joints/Arthritis
8) Y N …Recurrent migraine headaches

VI. GI/GU: Do you have/had:

1) Y N …Acid Reflux/Heartburn
2) Y N …Difficulty swallowing
3) Y N …Excessive thirst
2) Y N …Hepatitis

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3) Y N …Chron's/Colitis
4) Y N …Liver disease
5) Y N …Kidney disease/dialysis/transplant
6) Y N …Frequent vomiting
7) Y N …Blood in stool/urine
8) Y N …Frequent urination

VII. HEMATOLOGY/ENDOCRINE/IMMUNE: Do you have/had:

1) Y N …Anemia
2) Y N …Thyroid problems
3) Y N …Diabetes
4) Y N …Rheumatoid Arthritis
5) Y N …Auto-immune Disorder: _____
6) Y N …Sexually Transmitted Disease
7) Y N …HIV/AIDS
8) Y N …Persistent swollen lymph glands in the neck
9) Y N …Lymphoma/Leukemia/Bone marrow transplant
10)Y N …Prolonged bleeding (>10 minutes)/ Easy bruising
11)Y N …Hemophilia
12)Y N …Received a Blood Transfusion
If yes, for what reason:_____
13)Y N …Cancer/tumor
If yes, what kind:_____
Did you receive chemotherapy and or radiation?_____
14)Y N …Canker sore/Cold sore

VIII. SOCIAL/PSYCH: Have you been treated for any of the following:

1) Y N …Depression/Anxiety
2) Y N …Bipolar/Schizophrenia
3) Y N …Panic Attacks
4) Y N …Autism
5) Y N …Attention Deficit/Hyperactivity Disorder
6) Y N …Recreational Drug Use
7) Y N …Intravenous Drug Use
8) Y N …Alcohol Use
If yes, how often?_____
9) Y N …Tobacco use
If yes, how much do you smoke a day? _____
How many years have you smoked? _____

IX. ALLERGIES: Do you have allergies/reactions to the following:

1) Y N …Latex
2) Y N …Local/dental anesthetics
3) Y N …Penicillin or Other Antibiotics _____
4) Y N …Sulfa drugs
5) Y N …Barbituates, Sedatives, or sleeping pills
6) Y N …Aspirin

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7) Y N …Codeine
8) Y N …Other Drug(s):_____

X. SKELETAL:

1) Y N …Osteoporosis
2) Y N …Bone infections
3) Y N …Total/Partial joint replacement
   If yes, which joint?_____
4) Y N …Taken any Oral, Intravenous Bisphosphonates or other medications for your bones (ex. Fosamax, Boniva, Zometa, Aredia, Prolia, Actonel, Forteo)

XI. FEMALES ONLY

1) Y N …Are you pregnant or trying to get pregnant
   If yes, when are you due?_____
2) Y N …Are you nursing
3) Y N …Are you taking Birth Control
4) Y N …Hormone Therapy
5) Y N …Menopause

X. SLEEP APNEA

1) Y N …Do you snore or have you ever been told that you snore?
2) Y N …Have you ever been told you stop breathing while asleep?
3) Y N …Have you been diagnosed with sleep apnea?
4) Y N …Are you currently using a CPAP machine?
   If yes, would you prefer an oral appliance?_____

XI. Do you have any other medical conditions that are not listed on this form?
If yes, please explain:_____
_____
_____

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. I also understand that this information will be held in the strictest of confidence and is my responsibility to inform this office of any changes to my medical status.

_____ _____
(Patient Signature) (Date)