Medical History Form
Dr. Joel Sanders, D.D.S.
489 Laurel Avenue
Highland Park, IL. 60035
(847) 432-6501

Date: _____

Name:_____ Home Phone:_____

Address:_____ Business Phone/Cell: _____

City:_____ State_____ Zip Code_____

Date of Birth __/__/____ Sex M F Height_____Weight_____ Single___ Married___

Name of Spouse (if applicable)_____ Phone:_____

If filling out form for a minor, what is your relationship to that person?
Do you carry dental insurance? Y N If so, who carries the policy?
Insurance carrier's name, if other than patient_____ DOB__/___/_____
SS# of insurance carrier_____ Company holding policy_____
Email_____
Referred by:_____ Dental Insurance_____

Are you in good health?..... Yes No
Any change in your general health within the past year?..... Yes No
Your last physical exam was on_____
Are you currently under the care of a physician?..... Yes No
If so, what is being treated?_____
Any serious illness, operation, or been hospitalized in the past 5 years?..... Yes No
If yes, please explain_____

Are you taking any medications or medicine? (Including non-prescription)……..Yes No
If yes, what are you taking?_____

Diseases or Problems

Damaged heart valves or artificial heart valves, heart murmur or
rheumatic Heart disease…… Yes No
Cardiovascular disease (heart trouble, high blood pressure, arteriosclerosis, stroke)…….Yes No
Chest Pain upon exertion?..... Yes No
Shortness of breath?..... Yes No
Ankle Swelling?..... Yes No
Inborn heart defects?..... Yes No
Do you have a cardiac pacemaker?..... Yes No
Allergy?..... food…… airborn……Meds?..... Yes No
Sinus Trouble?..... Yes No
Asthma or hay fever?..... Yes No
Fainting spells or seizures?.....Yes No
Persistent weight loss?.....Yes No
Diabetes?.....Yes No
Hepatitis, jaundice or liver disease?.....Yes No
AIDS or HIV Infection?.....Yes No
Thyroid Problems?.....Yes No
Respiratory problems, emphysema, bronchitis…… Yes No
Arthritis or painful joints?..... Yes No

Stomach ulcer or hyperacidity……..
Kidney Trouble?..... Yes No
Tuberculosis…… Yes No
Persistent swollen glands in neck area?..... Yes No
Low blood pressure?..... Yes No
Sexually transmitted disease?..... Yes No
Epilepsy or other neurological disease?..... Yes No
Problems with mental health?..... Yes No
Cancer?..... Yes……. No…….. If yes, where?_____ Yes No
Immune System Problems?..... Yes No
Abnormal bleeding?..... Yes No
Blood transfusion?..... Yes No
Blood disorder?.,……. Yes No
Treatment for growth or tumor?..... Yes No
Are you allergic or have you had a reaction to
- Local anesthetics?..... Yes No
- Penicillin or other antibiotics?..... Yes No
- Sulfa drugs?..... Yes No
- Barbituates, sedatives, or sleeping pills?..... Yes No
- Aspirin?..... Yes No
- Iodine?..... Yes No
- Codeine or other narcotics?..... Yes No

Other?_____

Any serious trouble associated with any previous dental treatment?
If so, please explain_____

Are you wearing contact lenses?..... Yes No
Is there any other health condition or problem not listed that we should be aware of? Yes No

Please explain_____

Are you wearing any removable dental appliances?..... Yes No
Are you pregnant?..... Yes No
Are you nursing?..... Yes No
Are you taking birth control pills?..... Yes No
Dental concerns?_____

I certify that I have read and understood the above. I acknowledge that my questions, if Ajy, about the inquiries set forth above have been answered to my satisfaction. I will not Hold Dr. Sanders, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ Date_____
Signature of Patient/authorized adult