PATIENT MEDICAL HISTORY

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ SEX: MALE / FEMALE

For our confidential records, please circle yes or no to the following questions, as they apply to you.

1. Are you in good health: Yes No
2. Has there been any change in your health in the past year? Yes No
3. My last physical exam was on _____/_____/_____
4. Are you currently under the care of a physician? Yes / No Name & Address of Dr. _____
5. Have you had any serious illness, operation, or hospitalization within the past 5 years? Yes No
6. Are you taking any medications including non-prescription, homeopathic "natural" remedies ~ including diet pills Yes No
   Please list? _____
7. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur. Yes No
   b. Rheumatic Heart Disease. Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition. Yes No
   d. Allergies Yes No
   e. Sinus trouble Yes No
   f. Asthma or hay fever Yes No
   g. Fainting spells or seizures Yes No
   h. Diabetes Yes No
   i. Hepatitis, jaundice or liver disease Yes No
   j. Frequent or recurring mouth sores Yes No
   k. Thyroid problems Yes No
   l. Respiratory problems, emphysema, bronchitis, ect. Yes No
   m. Arthritis or painful swollen joints, including jaw joint (TMJ) Yes No
   n. Stomach ulcer or hyperacidity Yes No
   o. Kidney trouble Yes No
   p. Tuberculosis Yes No
   q. Persistent cough or cough that produces blood Yes No
   r. Low blood pressure Yes No
   s. Epilepsy or neurological disorder Yes No
   t. Cancer Yes No
   u. Are you taking vitamins or homeopathic remedies? Yes No
   v. Any disease, drug, or transplant operation that has depressed your immune system Yes No
8. Have you had abnormal bleeding? Yes No
9. Have you ever required a blood transfusion? Yes No
10. Do you have any blood disorder such as anemia? Yes No
11. Have you ever had treatment for a tumor or growth? Yes No
12. Are you allergic to or have you had a reaction to?
    a) Local anesthetics Y / N
    b) Penicillin or antibiotics Y / N
    c) Sulfa drugs Y / N
    d) Barbiturates or sleeping pills Y / N
    e) Aspirin Y / N
    f) Iodine Y / N
    g) Codeine or other narcotics Y / N
    h) Latex or rubber products Y / N
    i) Other: _____

PATIENT MEDICAL HISTORY

13. Do you have any other condition or disease you think the doctor should know about? Yes No
14. Do you use tobacco products? Yes / No How much and how often? _____
15. Do you use alcohol? Yes / No How much and how often? _____
16. Do you use or have you used an illegal / street drugs? Yes / No How much and how often? _____
17. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel or osteoporosis, chemotherapy for multiple myeloma) Yes /No
18. Have you ever had a joint replaced? Yes / No
19. Are you wearing contact lenses? Yes / No
20. Do you wish to speak with the doctor privately about anything? Yes / No

WOMEN

21. Are you pregnant or trying to become pregnant? Yes / No
22. Do you have problems associated with your menstrual period? Yes / No
23. Are you nursing? Yes / No
24. Are you taking birth control pills? Yes / No

CHIEF DENTAL COMPLAINT

25. Are you having any discomfort at this time? Yes / No
26. Have you had any serious trouble associated with previous dental treatment? Yes / No
27. Does dental treatment make you nervous: No_____Slightly_____ Moderately_____Extremely
28. Date of your last dental visit: _____
29. Are you wearing removable dental appliances? Yes / No
30. Have you ever been treated for periodontal disease (gum disease, pyorrhea, or trench mouth)? Yes / No If so, when _____
31. How often do you brush? _____
32. Type of tooth brush used: Soft Medium Hard
33. Do you use dental floss? Yes / No Fluoride rinse? Yes / No
34. Do you have or have you ever had any of the following:

MOUTH:		TEETH:	
Bleeding, sore gums	Yes / No	Loose teeth	Yes / No
Unpleasant taste in your mouth / bad breath	Yes / No	Sensitive to hot	Yes / No
Burning tongue / lips	Yes / No	Sensitive to cold	Yes / No
Frequent blisters in the mouth or on the lips	Yes / No	Sensitive to sweets	Yes / No
Swelling / lumps on the mouth	Yes / No	Sensitive to biting	Yes / No
Ortho treatment (braces)	Yes / No	Food impaction	Yes / No
Biting cheeks / lips	Yes / No	Clenching / Grinding	Yes / No
Clicking / popping jaw	Yes / No	If so when _____	
Difficulty opening or closing jaw	Yes / No	Shifting in bite	Yes / No
		Change in bite	Yes / No

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 not hold my dentist, or any member of the staff, responsible for any errors or omissions that I may have mad in the completion of this form.

Date _____ Patient's / Guardian's Signature: _____

Date _____ Doctor's Signature: _____