

PATIENT NAME _____

Confidential Patient Medical History

MEDICAL DOCTOR _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

ARE YOU ALLEGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

ARE YOU UNDER MEDICAL TREATMENT NOW? **Y N**

WHAT IS YOUR CONDITION _____

DO YOU USE TOBACCO? **Y N**
 LOCAL ANESTHETICS (EG. NOVOCAINE) **Y N**
 PENICILLIN ASPIRIN

--- ARE YOU INTERESTED IN QUITTING? **Y N**
 OTHER ANTIBIOTICS LATEX SEDATIVES

DO YOU USE ALCOHOL? **Y N**
 OTHER ALLERGIES PLEASE LIST _____

DO YOU USE COCAINE? **Y N**

DO YOU USE OTHER STREET DRUGS? **Y N**

FOR WOMEN ONLY:

YOU HAVE A PERSISTENT COUGH -NOT ASSOCIATED WITH A KNOWN ILLNESS LASTING MORE THAN 3 WEEKS **Y N**
 ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?
 ARE YOU NURSING?
 ARE YOU TAKING BIRTH CONTROL PILLS?

ARE YOU TAKING OR HAVE YOU TAKEN MEDICINE FOR BONE DENSITY PROBLEMS (SUCH AS ZOMETA OR FOSOMAX) IF YES HOW LONG? **Y N**
 DRUG NAME _____

PLEASE LIST ALL MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING: _____

Y N	Y N	Y N
<input type="radio"/> <input type="radio"/> HIGH BLOOD PRESSURE	<input type="radio"/> <input type="radio"/> HEART DISEASE / DEFECT	<input type="radio"/> <input type="radio"/> STROKE
<input type="radio"/> <input type="radio"/> HEART ATTACK	<input type="radio"/> <input type="radio"/> CARDIAC PACEMAKER	<input type="radio"/> <input type="radio"/> HAY FEVER / ALLERGIES
<input type="radio"/> <input type="radio"/> RHEUMATIC FEVER	<input type="radio"/> <input type="radio"/> HEART MURMUR	<input type="radio"/> <input type="radio"/> TUBERCULOSIS
<input type="radio"/> <input type="radio"/> FAINTING / SEIZURES	<input type="radio"/> <input type="radio"/> ANGINA, CHEST PAINS	<input type="radio"/> <input type="radio"/> RADIATION THERAPY
<input type="radio"/> <input type="radio"/> ASTHMA	<input type="radio"/> <input type="radio"/> ANEMIA	<input type="radio"/> <input type="radio"/> GLAUCOMA
<input type="radio"/> <input type="radio"/> LOW BLOOD PRESSURE	<input type="radio"/> <input type="radio"/> EMPHYSEMA	<input type="radio"/> <input type="radio"/> LIVER DISEASE
<input type="radio"/> <input type="radio"/> EPILEPSY / CONVULSIONS	<input type="radio"/> <input type="radio"/> CANCER	<input type="radio"/> <input type="radio"/> HEART TROUBLE
<input type="radio"/> <input type="radio"/> LEUKEMIA	<input type="radio"/> <input type="radio"/> ARTHRITIS	<input type="radio"/> <input type="radio"/> RESPIRATORY PROBLEMS
<input type="radio"/> <input type="radio"/> DIABETES, TYPE I OR II	<input type="radio"/> <input type="radio"/> JOINT REPLACEMENT OR IMPLANT	<input type="radio"/> <input type="radio"/> PARKINSONS / DEMENTIA
<input type="radio"/> <input type="radio"/> KIDNEY DISEASES	<input type="radio"/> <input type="radio"/> STOMACH TROUBLES / ULCERS	<input type="radio"/> <input type="radio"/> THYROID PROBLEM
<input type="radio"/> <input type="radio"/> AIDS OR HIV INFECTION		

LIST OTHER MEDICAL CONDITIONS WE SHOULD KNOW ABOUT _____

PATIENT DENTAL HISTORY

Y N	Y N
<input type="radio"/> <input type="radio"/> DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	<input type="radio"/> <input type="radio"/> DO YOU HAVE FREQUENT HEADACHES?
<input type="radio"/> <input type="radio"/> ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	<input type="radio"/> <input type="radio"/> DO YOU CLENCH OR GRIND YOUR TEETH?
<input type="radio"/> <input type="radio"/> DO YOU HAVE SLEEP APNEA?	<input type="radio"/> <input type="radio"/> DO YOU SNORE LOUDLY?
<input type="radio"/> <input type="radio"/> DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	<input type="radio"/> <input type="radio"/> HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS?
<input type="radio"/> <input type="radio"/> DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	<input type="radio"/> <input type="radio"/> PROLONGED BLEEDING AFTER ANY EXTRACTIONS?
<input type="radio"/> <input type="radio"/> HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	<input type="radio"/> <input type="radio"/> HAVE YOU EVER HAD ORTHODONTIC TREATMENT?
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	<input type="radio"/> <input type="radio"/> HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?
<input type="radio"/> <input type="radio"/> A) CLICKING?	<input type="radio"/> <input type="radio"/> ARE YOU UNHAPPY WITH THE APPEARANCE OF YOUR TEETH? IF YES, WHAT WOULD YOU LIKE TO CHANGE ABOUT THEM?
<input type="radio"/> <input type="radio"/> B) PAIN (JOINT, EAR, SIDE OF FACE)?	_____
<input type="radio"/> <input type="radio"/> C) DIFFICULTY IN OPENING OR CLOSING?	_____
<input type="radio"/> <input type="radio"/> D) DIFFICULTY IN CHEWING?	_____

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X

PATIENT, PARENT OR GUARDIAN

DATE

DOCTOR INITIAL

UPDATED MEDICAL HISTORY

UPDATED MEDICAL HISTORY

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DATE

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