

## PATIENT MEDICAL HISTORY

Physician:	Office Phone:	Date of Last Exam:
Are you under medical Treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been hospitalized for any surgical or serious illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, What medication(s) are you taking?		
Do you use Tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you allergic to or have you had any reactions to the following?	
Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Local Anesthetics (Novocain)	<input type="checkbox"/> Penicillin or Other Antibiotics
Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Barbiturates
Do you take any medicine for osteoporosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Iodine
	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Other
<b>WOMEN ONLY</b>		
Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please check if you have or have had any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Cardiac Pacemaker	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Stroke	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Angina	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fainting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Frequently Tired
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Cancer	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Joint Replacement or Implant
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Kidney Diseases	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> AID or HIV Infection	<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Stomach Troubles/ Ulcers	<input type="checkbox"/> Other	COMMENTS:	

## PATIENT DENTAL HISTORY

Do your gums bleed while brushing or flossing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had any head, neck or jaw injuries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you teeth sensitive to hot/cold liquids/food?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are your teeth sensitive to sweet/sour liquids/foods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel pain to any of your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any sores/lumps in or near your mouth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had any difficult extractions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced any of the following in your jaw?			Have you had orthodontic (braces) work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain? <input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had prolong bleeding following extraction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty opening or closing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had instructions on the correct method of brushing your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty in chewing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had instructions on the care of your gums?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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.

SIGNATURE **X**

Date: