

NAME: _____ Date of Birth: _____

PATIENT MEDICAL HISTORY:

CIRCLE

1. Have you been under the care of a physician during the last two years? **YES NO**
If Yes, please describe condition: _____
Physicians name _____ Phone _____
2. Have you taken any medications/prescriptions during the past two years? **YES NO**
If Yes, please list: _____

3. Do you have any known allergies? **YES NO**
If Yes, please list: _____
4. Have you been hospitalized or had any surgery in the past 5 years? **YES NO**
If Yes, please describe: _____
5. If female, are you now pregnant? Due date? _____ **YES NO**
Are you currently nursing? **YES NO**
6. *If you have had any of the following conditions, circle "Yes" & indicate Month/Year, if not circle "No".*

Yes No AIDS/HIV	Yes No Developmental Disabilities	Yes No Hyper/Hypo Thyroidism
Yes No Alcohol Addiction	Yes No Diabetes	Yes No Jaundice/Liver Disease
Yes No Allergies - Seasonal	Yes No Dizzy/Fainting Spells	Yes No Kidney Trouble
Yes No Anemia	Yes No Drug Addiction	Yes No Mental/ Nervous Disorder
Yes No Anorexia/Bulimia	Yes No Dry Mouth	Yes No Mitral Valve Prolapse____/____
Yes No Arthritis – OA or RA	Yes No Emphysema/Bronchitis	Yes No Osteoporosis/Bone Disease
Yes No Artificial Heart Valves____/____	Yes No Epilepsy/Seizures____/____	Yes No Psychiatric Treatment
Yes No Artificial Joints____/____	Yes No Fibromyalgia	Yes No Radiation Treatment____/____
Yes No Asthma	Yes No Heart Attack____/____	Yes No Rheumatic Fever
Yes No Cancer/Tumors	Yes No Heart Disease	Yes No Sinus Trouble
Yes No Chemotherapy____/____	Yes No Heart Pacemaker	Yes No Stroke____/____
Yes No Chest Pains	Yes No Heart Surgery____/____	Yes No Tuberculosis____/____
Yes No Cold Sores	Yes No Hepatitis____/____	Yes No Ulcers
Yes No Dementia/Alzheimer's Disease	Yes No High Blood Pressure	Yes No Other_____

Do You Use Tobacco? Yes No

Cigarettes – Packs/Day: _____ Chew - #/Day: _____ Pipe - #/Day: _____ Cigars - #/Day: _____

PATIENT DENTAL HISTORY

1. How long has it been since your last dental visit? _____
2. Are you having any specific problems with your teeth, gums or mouth at this time? **YES NO**
If Yes please list _____
3. Do you clench or grind your teeth? If Yes, When? Day or Night **YES NO**
4. Do you notice any popping, clicking or soreness in the jaw? **YES NO**
5. Have you undergone any previous periodontal surgery or oral surgery? **YES NO**
If Yes, please list _____
6. Have you had any head, neck or jaw injuries? **YES NO**
7. Have you had any serious trouble associated with any previous dental treatment? **YES NO**
If Yes, please list _____
8. Have you ever experienced any ill effects from dental anesthetics, antibiotics or any other drug? **YES NO**
If Yes, please list _____

Signature: _____ Relationship to Patient: _____ Date: _____

Doctor's Signature: _____ Date: _____ B/P: _____ Pulse: _____