Patient Medical History for: *(Please Print Name)* ____________________

1. Name of Physician and Phone #____________________
2. Are you under medical treatment now? ____________________
3. Have you ever been hospitalized for any surgical operations or serious illness within past 5 years? □ Yes □No

If yes, explain:____________________

4. Are you taking any medication(s) including non-prescription medicine? □ Yes □No

If yes, please list____________________

Do You Have or Have Had any of the Following:	YES	NO
Anemia	□	□
Emphysema	□	□
Cancer	□	□
Arthritis	□	□
Joint Replacement/ Implant If Yes, explain ____________________	□	□
Hepatitis A, B, C/ Jaundice (circle)	□	□
STD	□	□
Stomach Troubles/ Ulcer	□	□
Chest Pains	□	□
Frequent Headaches/ Migraines (circle)	□	□
Stroke If Yes, when: ____________	□	□
Hay Fever/ Allergies	□	□
Tuberculosis	□	□
Radiation/ Chemotherapy	□	□
Glaucoma	□	□
Recent Weight Loss	□	□
Liver Disease	□	□
Fainting/ Dizziness	□	□
Seizures	□	□
Epilepsy/ Convulsions If Yes, Date of Last Episode ____________________	□	□
Asthma	□	□
Low/ High Blood Pressure (circle)	□	□
Blood Transfusion	□	□
Leukemia	□	□
Diabetes I/ Diabetes II (circle)	□	□
Sinus Problems	□	□
Kidney Disease/ Dialysis (circle)	□	□
Pneumonia	□	□
HIV/ AIDS	□	□
Thyroid Problems	□	□
Heart Disease	□	□
Cardiac Pace Maker	□	□
Heart Murmur	□	□
Angina If Yes, when ____________________ Aura Present? ____________________	□	□
Heart Attack If Yes, when ____________________	□	□
Rheumatic Fever	□	□
Mitral Valve Prolapse	□	□
Snoring / Sleep Apnea	□	□

	YES	NO
Acid Reflux/ GERD	□	□
Parkinson's Disease	□	□
Problems Swallowing	□	□
Persistent Cough (more than 3 weeks)	□	□
Skin Graft If Yes, Explain ____________________	□	□
Other____________________	□	□
Are You Allergic or Have Had Any Reaction to the Following:		
Local Anesthetic	□	□
Penicillin	□	□
Amoxicillin	□	□
Erythromycin	□	□
Sulfa Drugs	□	□
Barbiturates	□	□
Sedatives	□	□
Iodine	□	□
Aspirin	□	□
Any Metals (Nickel, Mercury, Silver, etc.)	□	□
Latex Rubber	□	□
Other ____________________	□	□
For Women Only:		
Are You Pregnant / Think You May Be If Yes, How Many Weeks ____________	□	□
Are You Nursing	□	□
Taking Oral Contraceptives	□	□
Are You on Hormone Replacement Therapy	□	□
Taking Calcium Replacement Medications	□	□
Dental History:		
Name of Previous Dentist ____________________ Phone ____________________ Date of Last Exam____________________ Date of Last Xrays____________________		
Do your gums bleed when brushing or flossing?	□	□
Teeth Sensitive to Hot/Cold/Sweets? If Yes, Please circle one	□	□
Do you feel pain in any of your teeth?	□	□
Do you have any sores/lumps in or near your mouth?	□	□
Any head, neck, or jaw injuries?	□	□
Do you have clicking, popping, pain, or trouble when opening, chewing or closing your jaw?	□	□
Have you had Orthodontic Treatment? When____________________	□	□
Do you use tobacco products?	□	□
Do you Clench or grind your teeth?	□	□
Do you have a Denture/ Partial/ Implant/ Bridges?	□	□