

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 _____

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

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

[Type text]