PATIENT'S NAME _____ TODAY'S DATE____/____/_____
Date of birth: ____/___/____

Physician name:_____ Tele # _____
Emergency Contact NAME:_____ Tele #_____

MEDICAL HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Are you in good health? YES NO Date of last physical examination_____

Has there been any change in your general health within the past year? YES NO
If yes, what has changed?_____

Are you now under the care of a physician? YES NO
If yes, for what condition are you being treated?_____

Have you ever had any serious illness, operation or been hospitalized? YES NO
If yes, what was the illness or problem?_____

Are you taking any medicine(s) including non prescription vitamins or medications? YES NO
If yes, what are you taking? _____
Are you taking any bisphosphonate drugs such as IV Aredia or Zometa? YES NO OTHER _____

Do you have or have you had any of the following diseases or problems?

Damaged or artificial heart valves	YES NO	Stomach ulcer	YES NO
Heart murmur	YES NO	Stomach hyperacidity	YES NO
Rheumatic heart disease	YES NO	Persistent diarrhea	YES NO
Cardiac pacemaker	YES NO	Recent weight loss	YES NO
Heart attack	YES NO	Diabetes	YES NO
Coronary Insufficiency	YES NO	Hepatitis	YES NO
High blood pressure	YES NO	Liver disease	YES NO
Low blood pressure	YES NO	Kidney trouble	YES NO
Stroke	YES NO	Cancer	YES NO
Pain upon exertion	YES NO	Tumor/growth	YES NO
Shortness of breath	YES NO	Immune disease	YES NO
Swollen ankles	YES NO	AIDS or HIV infection	YES NO
Sinus trouble	YES NO	Tuberculosis	YES NO
Asthma	YES NO	Sexually transmitted disease	YES NO
Emphysema	YES NO	Abnormal bleeding	YES NO
Bronchitis	YES NO	Blood disorder	YES NO
Persistent cough	YES NO	Blood transfusion	YES NO
Allergies	YES NO	Allergy or reaction to:	
		• Local anesthetics……	YES NO
Fainting spells	YES NO	• Penicillin……	YES NO
Seizures	YES NO	• Tetracycline……..	YES NO
Epilepsy	YES NO	• Sulfa drugs……	YES NO
Neurological disease	YES NO	• Barbiturates / sedatives…..	YES NO
Problems with mental health	YES NO	• Aspirin……	YES NO
Thyroid problems	YES NO	• Iodine……..	YES NO
Arthritis	YES NO	• Codeine / narcotics……..	YES NO
Do you smoke?	YES NO	• Latex……	YES NO
Artificial joints	YES NO	• Other……..	YES NO
SEE OTHER SIDE			

Women:

Are you pregnant?	YES NO
Are you anticipating becoming pregnant?	YES NO
Are you nursing?	YES NO
Do you have any problems associated with your menstrual period?	YES NO
Have you had a hysterectomy or other female surgery?	YES NO
Are you in or have you passed through menopause (life change)	YES NO
Are you taking birth control pills?	YES NO
Are you taking hormone replacement pills?	YES NO
Are you aware of having Osteopenia or Osteoporosis? Do you take Fosomax, Boniva, Actonel, or other Osteoporosis medication? YES NO If yes, How long have you been taking it?_____	YES NO

Do you have any disease, condition, or problem not listed above that you think I should know about? YES NO
If yes, please explain? _____
_____

DENTAL HISTORY

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation ☐ Periodontal Maintenance

Are you in pain: ☐ No ☐ Yes How Long? _____

Please indicate with a √ any of the following problems:

☐ Discomfort, clicking or popping in jaw.
☐ Red, swollen or bleeding gums.
☐ Sensitive tooth, teeth or gums.
☐ Blisters/Sores in or around the mouth.
☐ Other:_____
☐ Lost/Broken Filling (s)
☐ Teeth grinding
☐ Ringing in ears
☐ Broken/Chipped tooth
☐ Stained teeth
☐ Locking Jaw
☐ Bad breath

Have you had any serious trouble associated with any previous dental treatment? YES NO
If yes, please explain? _____

Do you require pre-medication for dental treatment? ☐ No ☐ Yes ☐ Don't know

Last Dental exam: ____/_____/_____ Last Dental X-rays: _____/_____/_____

Times a day you brush?_____ Times a week you floss? _____

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient:_____

Medical History Summary: (for completion by the doctor**)**

_____

_____

_____

Signature of Doctor:_____