

MEDICAL HISTORY

NAME: _____ Date of Birth: _____

Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past year? Yes No
2. Are you now under the care of a physician? Yes No
 - a. If so, what is the condition being treated? _____
3. The name of physician _____
4. Have you been hospitalized or had a serious illness within the past 5 years? Yes No
5. Do you have, or have you had, any of the following diseases or problems?

Rheumatic fever or rheumatic heart disease	Yes No
Mitral Valve Prolapse	Yes No
Heart Murmur	Yes No
Congenital heart lesions	Yes No
Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, pacemaker, artificial heart valves)	Yes No
Cancer (chemotherapy, radiation)	Yes No
Allergy	Yes No
Sinus trouble	Yes No
Asthma or hay fever	Yes No
Fainting spells, dizziness, Epilepsy, or seizures	Yes No
Diabetes	Yes No
Hepatitis, jaundice, or liver disease	Yes No
Arthritis	Yes No
Inflammatory rheumatism (painful, swollen joints)	Yes No
Osteoporosis	Yes No
Artificial joints	Yes No
Kidney trouble	Yes No
Respiratory Problems, Emphysema	Yes No
Tuberculosis	Yes No
Persistent cough or cough up blood	Yes No
Low blood pressure	Yes No
Sexually Transmitted Disease	Yes No
AIDS or HIV	Yes No
Are you at high risk of HIV?	Yes No
Abnormal bleeding	Yes No
Bruise easily	Yes No
Blood transfusion	Yes No
Blood Disease	Yes No
Anemia	Yes No
Mental or physical disability	Yes No
Glaucoma	Yes No
Ulcers	Yes No
6. Have you ever used Phen-Fen or other diet suppression combination for weight loss? Yes No
 - a. If so, have you been evaluated by your physician or cardiologist or have you undergone an EKG? Yes No
7. Have you had surgery or x-ray treatment for tumor, growth, or other condition of your head or neck? Yes No
8. Are you taking any drugs or medications? Yes No
 - a. If so, what? _____

9. Are you taking any of the following?:

a. Antibiotics	Yes No
b. Anticoagulants (blood thinners)	Yes No
c. Medicine for high blood pressure	Yes No
d. Cortisone (steroids)	Yes No
e. Tranquilizers	Yes No
f. Antihistamines	Yes No
g. Aspirin	Yes No
h. Insulin, tolbutamide (Orinase) or similar drug	Yes No
i. Digitalis or drugs for heart trouble	Yes No
j. Nitroglycerin	Yes No
k. Oral contraceptive or other hormonal therapy	Yes No
l. Other _____	
10. Are you allergic or have you reacted adversely to any of the above? Yes No
 - a. Any other? _____
11. Do you use tobacco products? Yes No
12. Have you had any serious trouble associated with any previous dental treatment? Yes No
13. Do you have any disease, condition, or problem not listed above? Yes No
14. Do you have any allergies to metal or jewelry? Yes No

WOMEN

15. Are you pregnant? Yes No

DENTAL HISTORY & TMJ

1. Do you have pain from heat, cold, or sweets? Yes No
2. Have you lost any of your teeth? Yes No
 - a. If so, how long have they been missing? _____
3. Do your gums bleed when brushing or flossing? Yes No
4. Do you have pain from biting or chewing? Yes No
5. Experience ringing in your ears? Yes No
6. Do you clench your teeth? Yes No
7. Do you have difficulty opening or closing your mouth? Yes No
8. Do you have headaches? Yes No
9. Do you have clicking or popping by your ears when you open or close your mouth? Yes No
10. Do you have eye or facial swelling? Yes No
11. Do you have neck problem? Yes No
12. Do you have back problems? Yes No
13. Are you satisfied with the appearance of your teeth? Yes No

What did you like about your last dental office? _____

What did you dislike about your last dental office? _____

CHIEF DENTAL COMPLAINT: _____

Signature of Patient *Date*

Signature of Doctor *Date*