PATIENT MEDICAL HISTORY

PHYSICIAN NAME ___________________________OFFICE PHONE _________________ DATE OF LAST PHYSICAL ______________

		YES	NO
1.	ARE YOU UNDER MEDICAL TREATMENT NOW?	__	__
2.	HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	__	__

IF YES, PLEASE EXPLAIN.

____

____

3.	ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	__	__

IF YES, WHAT MEDICATION(S) ARE YOU TAKING?

____

____

4.	DO YOU USE TOBACCO?	__	__
5.	DO YOU USE ALCOHOL?	__	__
6.	DO YOU USE ANY RECREATIONAL DRUGS?	__	__
7.	ARE YOU WEARING CONTACT LENSES?	__	__

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS?

____

____

9. ARE YOU ALLERGIC TO LATEX? __ Y __ N

10. MY PHYSICIAN REQUIRES ANTIBIOTICS FOR DENTAL WORK? __ Y __ N

WOMEN ONLY:

A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? __ Y __N

B) ARE YOU NURSING? __ Y __ N

C) ARE YOU TAKING BIRTH CONTROL? __ Y __ N

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11. **PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.**

__ HIGH BLOOD PRESSURE	__ HEART DISEASE	__ CHEST PAINS	__ KIDNEY DISEASES
__ HEART ATTACK	__ CARDIAC PACEMAKER	__ EASILY WINDED	__ AIDS OR HIV INFECTION
__ RHEUMATIC FEVER	__ HEART MURMUR	__ STROKE	__ THYROID PROBLEM
__ SWOLLEN ANKLES	__ ANGINA	__ HAY FEVER / ALLERIES	__ HEADACHE / MIGRAINE
__ FAINTING / SEIZURES	__ FREQUENTLY TIRED	__ TUBERCULOSIS	__ HEPATITIS / JAUNDICE
__ ASTHMA	__ ANEMIA	__ GLAUCOMA	__ SEXUALLY TRANSMITTED DISEASE
__ LOW BLOOD PRESSURE	__ EMPHYSEMA	__ RECENT WEIGHT LOSS	__ STOMACH TROUBLE / ULCERS
__ EPILEPSY / CONVULSIONS	__ CANCER	__ LIVER DISEASE	__ RESPIRATORY PROBLEMS
__ RADIATION THERAPY	__ LEUKEMIA	__ HEART TROUBLE	__ JOINT REPLACEMENT OR IMPLANT
__ ARTHRITIS	__ DIABETES	__ OTHER: IF NOT LISTED PLEASE EXPLAIN IN THE COMMENTS AREA	

COMMENTS

PATIENT DENTAL HISTORY

1. IS YOUR TOOTH SENSITIVE TO HOT OR COLD LIQUIDS / FOODS? ____
2. IS YOUR TOOTH SENSITIVE TO BITE OR CHEW FOODS? ____
3. DO YOU HAVE ANY SORES OR LUMPS NEAR YOUR TOOTH? ____
4. IS YOUR FACE SWOLLEN TODAY?______Y _______N
5. WHEN DID THE SWELLING START?____
6. DO YOU CLENCH OR GRIND YOUR TEETH? ____
7. HAVE YOU HAD ANY ORTHODONTIC WORK (BRACES)? ____
8. HAVE YOU HAD ANY TRAUMA OR INJURY TO THE MOUTH?____

X ____

SIGNATURE OF PATIENT OR PARENT IF MINOR

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