Medical History

Patient's Name _____ Date of Birth _____ /_____ /_____

Physician's Name _____ Phone Number _____

Are you now or have you been under a physician's care within the past year? Yes No

If yes, specify the condition being treated: _____

Check the following conditions that apply to you (Previous or Current):

	Yes	No
Cardiovascular		
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Artificial Valve	☐	☐
Other _____		
Psychological		
ADD/ADHD	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Other _____		
Musculoskeletal		
Fibromyalgia	☐	☐
Arthritis (Osteo)	☐	☐
Muscular Dystrophy	☐	☐
Gout	☐	☐
Artificial Joint	☐	☐
Other _____		
General		
Cancer	☐	☐
Kidney Disease	☐	☐
Hepatitis (circle)	A B C	
Prostate disease	☐	☐
AIDS/HIV positive	☐	☐

	Yes	No
Respiratory		
Asthma	☐	☐
COPD	☐	☐
Sleep Apnea	☐	☐
Other _____		
Neurologic		
Stroke	☐	☐
Seizure Disorder	☐	☐
Multiple Sclerosis	☐	☐
Other _____		
Endocrinology		
Type 1 Diabetes	☐	☐
Type 2 Diabetes	☐	☐
Thyroid Condition	☐	☐
Hormone Disorder	☐	☐
Other _____		
Autoimmune		
Systemic Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Sjogrens Syndrome	☐	☐
Other		
Unintentional weight loss	☐	☐
Chest Pain	☐	☐

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Please state any conditions not listed above

_____

LIST CURRENT MEDICATIONS

_____

_____

_____

_____

_____

LIST ALLERGIES

_____

_____

_____

_____

_____

(For Staff Use)

Initial Date

_____

_____

_____

_____

Have you received radiation therapy to the head or neck area? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphophonates? Yes No

Do you bleed excessively or do you take any type of blood thinner including aspirin? Yes No

Have you been told you require antibiotic premedication prior to dental treatment? Yes No

Do you smoke or chew? Yes No Do you drink alcohol? Yes No

Are you interested in quitting? Yes No Number of drinks a week _____

Dental History

Name of previous dentist _____

When was your last: Dental Visit _____

Full Set of X-rays _____

Cleaning _____

Reason for today's visit:_____

Are you apprehensive about dental treatment? Yes No

Have you had problems with previous dental treatment? Yes No

Are you unhappy with the appearance of your teeth? Yes No

Would you like a whiter smile? Yes No

Do you prefer to save your teeth? Yes No

Do your gums bleed easily? Yes No

Are your teeth sensitive? Yes No

How often do you:

Brush? _____

Floss? _____

Do you clench or grind your teeth frequently? Yes No

Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities? Yes No

Do you have any jaw symptoms or headaches upon awaking in the morning? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT or GUARDIAN _____ DATE _____

(For Staff Use)

Initial Date

_____

_____

_____

_____