PATIENT MEDICAL HISTORY

Patient Name: ____ DOB: _______________

Physician: ________________________ Office Phone: _______________ Last Exam: __________

Are you under medical treatment now? Yes No

Have you been hospitalized for any surgical operation or serious illness in the last 5 years? Yes No

- *If yes, please explain:* ____

____

List MEDICATIONS you are currently taking:

____

____

____

Do you use tobacco? Yes No

WOMEN ONLY: Are you currently pregnant? Yes No
Are you currently nursing? Yes No

PATIENT DENTAL HISTORY

Previous Dentist/Location: ____ Last Visit: __________

Do your gums bleed while brushing or flossing? Y

Are your teeth sensitive to hot/cold liquids/food? Y

Are your teeth sensitive to sweet/sour liquids/food? Y

Do you feel pain to any of your teeth? Y

Do you have any sores/lumps in or near your mouth? Y

Have you had any head/neck/jaw injuries? Y

Have you ever experienced any of the following:
Circle: Clicking
Pain (joint, ear, side of face)
Difficulty in opening or closing
Difficulty in chewing

Do you have frequent headaches? Y

Do you clench or grind your teeth? Y

Do you bit your lips/cheeks frequently? Y

Have you ever had any difficult extractions? Y

Have you had any prolonged bleeding after an extraction? Y

Have you had any orthodontic treatment? Y

Do you wear dentures/partials? Y
If yes, date of placement __________

- **Have you had x-rays taken at another office within the past 5 years? Yes No**
If so, may we request a copy of the x-rays? Yes No

- **Have you been advised to take a premed prior to dental appointments? Yes No**

ALLERGIES: *Are you allergic to or have you had any reactions to the following? Please circle below:*

Local Anesthetics (e.g. Novocain)	Penicillin	Latex
Sulfa Drugs	Any Metals (e.g. Nickel, Mercury)	Codeine
Other: ________________________	Other: ________________________	Other: ________________________

PROBLEMS: *Please circle (y) for any problems/issues that you currently have below:*

Acid Reflux/GERD	Y	Easily Winded	Y	Migraines	Y
ADHD	Y	Emphysema	Y	Mitral Valve Prolapse	Y
AIDS/HIV	Y	Endometriosis	Y	Multiple Sclerosis	Y
Allergies	Y	Fainting	Y	Osteoporosis	Y
Anxiety/Depression	Y	Fibromyalgia	Y	Pacemaker	Y
Arthritis	Y	Frequently Tired	Y	Parkinson's Disease	Y
Asthma	Y	Glaucoma	Y	POTS Syndrome	Y
Atrial Fibrillation (AFib)	Y	Gout	Y	Radiation Therapy	Y
Autism Spectrum	Y	Graves Disease	Y	Raynaud's Disease	Y
Barrett's Esophagus	Y	Grind/Clench Teeth	Y	Recent Weight Loss	Y
Bleeding Problems	Y	Hashimoto's	Y	Respiratory Problems	Y
Blood Clots	Y	Hearing Impaired	Y	Rheumatic Fever	Y
By-Pass Surgery	Y	Heart Attack	Y	Rheumatoid Arthritis	Y
Cancer	Y	Heart Disease	Y	Seizures	Y
Celiac Disease	Y	Heart Murmur	Y	Sleep Apnea	Y
Cerebral Palsy	Y	Hepatitis/Jaundice	Y	Stents	Y
Chest Pains	Y	High Blood Pressure	Y	Stroke	Y
Cholesterol Issues	Y	IBS	Y	Swollen Ankles	Y
Congestive Heart Failure	Y	Joint Replacement	Y	Thyroid Problems	Y
COPD	Y	Kidney Disease	Y	Ulcerative Colitis	Y
Crohn's Disease	Y	Lactose Intolerant	Y	Vertigo	Y
Dementia	Y	Liver Disease	Y	Other: ____________________	
Diabetes	Y	Low Blood Pressure	Y	Other: ____________________	
Diverticulitis	Y	Lupus	Y	Other: ____________________	
Dry Mouth	Y	Malignant Hyperthermia	Y	Other: ____________________	

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Signature of Patient (or Parent/guardian if under 18 years old) Date