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PATIENT MEDICAL HISTORY

Patient's Name: ____ Today's Date: _________________

(Circle appropriate Yes/No answers AND fill in additional information, if applicable):

Yes or No 1) Are you currently being treated for any medical condition(s)?
If "yes", what? ____
Treating Physician's Name(s):____

Yes or No 2) Have you ever had any major operations or illnesses?
If "yes", what? ____

Yes or No 3) Have you ever had any serious accident involving head injuries?
If "yes", explain ____

Yes or No 4) Do you have epilepsy or a seizure disorder?

Yes or No 5) Are you allergic to any of the following? ____ Penicillin; ____ Amoxicillin;
____ Keflex; ____ Aspirin; ____ Ibuprofen; ____ Codeine

Yes or No 6) Have you ever had any adverse reaction to any drugs?
What? ____

Yes or No 7) Are you being treated for high blood pressure? Date last checked: _________________

Yes or No 8) Do you have any respiratory (lung) disease? (e.g. asthma, emphysema, TB, pneumonia, etc.) If "yes", what? ____

Yes or No 9) Are you diabetic? ____ Diet-Controlled; ____ Oral Medication; ____ Insulin

Yes or No 10) Have you ever had rheumatic fever, even as a child?

Yes or No 11) Do you have either or both of the following? ____ arthritis; ____ rheumatism

Yes or No 12) Do you have or have you ever had a tumor/unusual growth? Describe: ______________

Yes or No 13) Have you ever had a bleeding disorder? (e.g. anemia, bruise easily, hemophilia)
If "yes", what type? ____

Yes or No 14) Do you have or have you ever had any type of heart disease? (e.g. heart attack, murmur, angina, palpitations, artificial valves) If "yes", what? ____________________

Yes or No 15) Do you have a pacemaker? If "yes", when was it placed? _________________________

Yes or No 16) Do you have stents?

Yes or No 17) Do you have any artificial joint replacements? If "yes", where are they located and when were they placed? ____

Yes or No 18) Have you ever had any type of liver disease? If "yes", what type? __________________

Yes or No 19) Have you ever had either of the following? ____ yellow jaundice; ____ hepatitis

Yes or No 20) Have you ever had any type of kidney disease? If "yes", what? ____________________

Yes or No 21) Have you ever had any type of stomach/intestinal disease? (e.g. ulcers, colitis, GERD)
If "yes", what? ____

Yes or No 22) Have you ever had any type of venereal disease? If "yes", what type? _______________

(Medical history questions are continued on back)

Yes or No 23) Do you have night sweats accompanied by weight loss or cough?

Yes or No 24) Are you allergic to anything causing hives, rash or asthma? If "yes", what? __________

Yes or No 25) Would you consider yourself in good general health at this time?

Yes or No 26) Have you ever had any wounds that healed slowly or had other complications?

Yes or No 27) Are you now pregnant, OR could you possibly be pregnant?

Yes or No 28) Do you have a history of fainting? Cause, if known: ________________________________

Yes or No 29) Have you ever had any type of radiation therapy (excluding routine X-rays)?

Yes or No 30) Have you ever had any growths/unusual sores in your mouth?
If "yes", describe: ____

Yes or No 31) Do you smoke or use smokeless tobacco? If "yes", how often? ______________________

Yes or No 32) Do you drink alcoholic beverages? If "yes", how much/how often? __________________

Yes or No 33) Have you ever had a local anesthetic shot in you mouth (to numb you)?
If "yes", did you have any adverse reaction to it? ____ Yes; ____ No

Yes or No 34) Have you ever had any extractions that were unusually difficult?
If "yes", what happened? ____

Yes or No 35) Have you ever had prolonged bleeding following an extraction?

Yes or No 36) Do your gums bleed? If "yes", how often? ____ Frequently; ____ Occasionally

Yes or No 37) Have you ever been taught how to properly brush and floss your teeth?

Yes or No 38) Do you floss your teeth regularly? If "yes", how often? ____________________________

Yes or No 39) Do you have a habit of clenching or grinding your teeth? If "yes", have you ever worn a biteguard as treatment for either or both of these problems? ____ Yes; ____ No

Yes or No 40) Do you have clicking or popping of your jaw joints? ____ Right; ____ Left; ____ Both

Yes or No 41) Do you ever have pain in your ears? ____ Now; ____ Frequently; ____ Occasionally

Yes or No 42) Have you had a FULL-MOUTH set of X-rays made in the last 3 years? (generally 18-20 pictures) If "yes", did you bring a copy with you today? ____ Yes; ____ No

Yes or No 43) Are you glad you are finished answering these questions?

Additional comments about your health that you feel we should be aware of:_________________________
____

List here, any drugs/medications you are presently taking and for what conditions, <u>OR</u> provide us with a list to copy for your file:

Medication:______________________________ Condition:____
Medication:______________________________ Condition:____
Medication:______________________________ Condition:____
Medication:______________________________ Condition:____

____ Date: ____________________
Signature of Patient, or Guardian/Responsible Person, if Patient is a minor