

Name _____
Last First M. In.

Residence _____ Date of Birth _____ Home Phone _____

PATIENT MEDICAL HISTORY

Name of personal physician _____ Office Phone _____

Address of personal physician _____

Approximate date of last physical examination _____ May we contact your physician regarding your health? Yes No

- 1. Are you undergoing any medical treatment now? Yes No
- 2. Have you had any major operations? If so what? Yes No
- 3. Have you ever had a serious accident involving head injuries? Yes No
- 4. Have you had any adverse response to any drugs including penicillin? If you have please list drugs on reverse side..... Yes No
- 5. Circle any of the following which you have had or have at present.

Heart Failure	Stroke	Blood Diseases	Yellow Jaundice	Heart Pacemaker
Heart Disease or Attack	Anemia	Scarlet Fever	HIV Positive	Heart Surgery
Angina Pectoris	Ulcers	Chronic Headache	Blood Transfusion	Heart Murmur
High Blood Pressure	TMJ/TMD	Allergies or Hives	Drug Addiction	Emphysema
Venereal Disease (Syphilis, Gonorrhea)	AIDS	Rheumatism	Hemophilia	Sinus Trouble
Rheumatic Fever	Cough	Artificial Joint	Cortisone Medicine	Diabetes
Congenital Heart Problems	Bruise	Thyroid Disease	Tuberculosis (TB)	Liver Disease
Chemotherapy (Cancer, Leukemia)	Asthma	Pain in Jaw Joints	Epilepsy of Seizures	Kidney Trouble
Artificial Heart Valve	Hay Fever	Hepatitis A (infectious)	Fainting or Dizzy Spells	Cold Sores
X-Ray Cobalt Treatment	Glaucoma	Hepatitis B (serum)	Sickle Cell Disease	Nervousness
Headaches at regular intervals	Arthritis	Hepatitis C	Psychiatric Treatment	Mitral Valve Prolapse
Malignancies				

- 6. Are you on a diet at this time? Yes No
- 7. Are you now taking drugs or medications? (Please list any medications you are taking on the back of this form.)..... Yes No
- 8. Are you allergic to any known materials or medication resulting - in hives, asthma, eczema, etc Yes No
- 9. Are you in general good health at this time? Yes No
- 10. Have any wounds healed slowly or presented other complications? Yes No
- 11. Do you smoke? Yes No
- 12. For Women: Are you pregnant? or do you think you may be pregnant? Yes No
- 13. For Women: Are you presently taking birth control pills? Yes No
- 14. Do you consume more than 3 oz. of alcohol per day? Yes No
- 15. Do you have a history of fainting? Yes No
- 16. Have you ever had any X-RAY TREATMENTS (other than diagnostic)? Yes No
- 17. Have you ever taken the appetite suppressant drug PONDIMIN (fenfluramine) or REDUX (dexphenfluramine)? Yes No
- 18. Have you ever taken or been administered any medication considered to be a bisphosphonate; such as but not limited to: risedronate sodium (chemical name) **ACTONEL** (brand name) by Procter & Gamble/Aventis, alendronate sodium (chemical name) **FOSAMAX** (brand name) by Merck, pamidronate disodium (chemical name) **AREDIA** (brand name) by Novartis, zoledronic acid (chemical name) **ZOMETA** (brand name) by Novartis? Yes No

PATIENT DENTAL HISTORY

Approximate date of last dental examination _____

Treatment done at last dental appointment _____

May we request your previous dental records? Yes No

Name of previous dentist? _____

- 1. Do you have pain in or near your ears? Or ringing in your ears? Yes No

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2. Do you have any unhealed injuries of inflamed areas in or around your mouth? Yes No
3. Have you experienced any growth or sore spots in your mouth? Yes No
4. Does any part of your mouth hurt when clenched? Yes No
5. Have you ever had a local dental anesthetic administered to you? Yes No
6. Have you ever had any reactions or allergic symptoms to any local anesthetic? Yes No
7. Have you ever had any difficult extractions in the past? Yes No
8. Have you ever had any prolonged bleeding following extractions in the past? Yes No
9. Have you ever had Trench Mouth? Yes No
10. Do your gums bleed? Yes No
11. Have you ever had instruction on the correct method of brushing your teeth? Yes No
12. Have you ever had instructions on the care of your gums? Yes No
13. Have you ever been treated for periodontal disease? Yes No
14. Do you chew on only one side of your mouth? If so why? Yes No
15. Do you at the present time have any dental complaints? Yes No
16. Do you clench or grind your teeth during the night or day? Yes No
17. When was your last full mouth X-RAY taken?.....Date: _____
18. Is any part of your mouth or are any of your teeth sensitive to pressure, cold/hot, sweets, touch, brushing, etc..... Yes No
19. If so which teeth or what areas _____

Do you have or have you had any of the following?

Dentures.....	Yes	No	Loose or broken fillings.....	Yes	No
Food impaction.....	Yes	No	Burning tongue.....	Yes	No
Swelling in mouth.....	Yes	No	Unpleasant taste.....	Yes	No
Lump in your mouth.....	Yes	No	Tired jaws.....	Yes	No
Lip or mouth blisters.....	Yes	No	Many cavities.....	Yes	No
Bad breath.....	Yes	No	Teeth sensitive to cold.....	Yes	No
Gag easily.....	Yes	No	Gum treatments.....	Yes	No
Teeth straightened.....	Yes	No	Mouth breathing.....	Yes	No
Loose teeth.....	Yes	No	Sounds in ear when chewing.....	Yes	No
Does your jaw pop or click.....	Yes	No			

How often do you brush your teeth? _____

Floss? _____

Are you dissatisfied with the alignment of your teeth? Yes No

Are you very apprehensive about receiving dental treatment? Yes No

Do you experience pain when in contact with any of the following?

Hot foods or liquids.....	Yes	No	Cold foods or liquids.....	Yes	No
Sweet foods or liquids.....	Yes	No	Sour foods or liquids.....	Yes	No

What prompted you to seek dental care at our office? _____

We would like to thank you for taking the time to fill out this boring Medical/Dental Health History Form. As trivial and non applicable to your dental concerns as some questions may seem to you, your responses to the questions provide us with the necessary information to provide you with the optimal dental care you expect from us.

Date _____ Patient's/Guardian's Signature _____

Date _____ Dentist's Signature _____