



**Medical History**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Date of last physical exam: \_\_\_\_\_ Physician's Name: \_\_\_\_\_  
 Physician's Phone#: \_\_\_\_\_

2. Have you been hospitalized in the past 5 years (if yes, explain below)? Yes No

3. Have you been under the care of a medical doctor during the past two years? Yes No  
 If yes, what for? \_\_\_\_\_

4. Have you ever had any excessive bleeding requiring special treatment? Yes No

5. **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic      Penicillin      Codeine      Other Antibiotic: \_\_\_\_\_  
 Latex      Acrylic      Metals      Other: \_\_\_\_\_

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax      Actonel      Boniva      For how long? \_\_\_\_\_  
 Areidia      Reclast      Zometa      When did you stop? \_\_\_\_\_

8. Please list other medications you are taking:

\_\_\_\_\_  
 \_\_\_\_\_

**Have you ever had any of the following?**

Chest Pains _____ YES/NO	Shortness of Breath _____ YES/NO	Hives/Skin Rashes _____ YES/NO
Heart Failure _____ YES/NO	Ulcers _____ YES/NO	Alcoholism _____ YES/NO
Heart Disease _____ YES/NO	Mental Health Issues _____ YES/NO	Drug Addiction _____ YES/NO
Heart Attack _____ YES/NO	Psychiatric Treatment _____ YES/NO	Glaucoma _____ YES/NO
Heart Problems _____ YES/NO	Fainting/Dizziness _____ YES/NO	Steroid Treatment _____ YES/NO
Angina Pectoris _____ YES/NO	Eating Disorder _____ YES/NO	Arthritis _____ YES/NO
Heart Surgery _____ YES/NO	Emphysema/COPD _____ YES/NO	Epilepsy/Seizures _____ YES/NO
Mitral Valve Prolapse _____ YES/NO	Persistent Cough _____ YES/NO	Diabetes _____ YES/NO
Hypertension _____ YES/NO	Tuberculosis _____ YES/NO	Birth Defects _____ YES/NO
Heart Murmur _____ YES/NO	Asthma _____ YES/NO	HIV+, AIDS _____ YES/NO
Rheumatic Fever _____ YES/NO	Hepatitis A, B, C, D _____ YES/NO	Hay Fever _____ YES/NO
Pacemaker _____ YES/NO	Liver Disease _____ YES/NO	Tobacco Products _____ YES/NO
Artificial Heart Valve _____ YES/NO	Sinus Trouble _____ YES/NO	Stroke _____ YES/NO

Sickle Cell Disease_____YES/NO	Bruise Easily_____YES/NO	Cold Sores_____YES/NO
Jaundice_____YES/NO	Artificial Joints_____YES/NO	Cancer_____YES/NO
Kidney Trouble_____YES/NO	Thyroid Disease_____YES/NO	Radiation Therapy_____YES/NO
Anemia_____YES/NO	Excessive Bleeding_____YES/NO	Chemotherapy_____YES/NO
Blood Transfusion_____YES/NO	Sexually Transmitted Disease__YES/NO	Trasplant_____YES/NO
Snore at night_____YES/NO	Other_____	
Sleep with CPAP/BiPAP __YES/NO	_____	

**Dental History**

1. Date of last dental exam:\_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_
2. Previous dentist's name / location:\_\_\_\_\_
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: \_\_\_\_\_

**Do you have any of the following dental concerns:**

- |  |        |               |               |
|--|--------|---------------|---------------|
| Clicking/popping in jaw joint          | Yes No |               |               |
| Pain in or around your ears            | Yes No | Swelling      | Bleeding Gums |
| Difficulty opening or closing          | Yes No | Bad Taste     | Bad Breath    |
| Difficulty chewing                     | Yes No | Food Catching | Tooth Pain    |
| History of trauma to jaw or face       | Yes No | Clenching     | Grinding      |
| Diagnosis of TMJ/TMD                   | Yes No | Other: _____  |               |
| Sensitivity to: Hot Cold Sweets Biting |        |               |               |

**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.**

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Doctor's Notes: