**MEDICAL HISTORY**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you under a physician’s care at the time? YES NO Since when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you taking any medications or herbal substances at the time, including birth control? YES NO

**List all**: Name: For what condition? Dose/Frequency of use:

A.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

F.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. **Allergic or unusual reactions**? YES NO

If yes check the following boxes which apply:

* Penicillin’s Other drugs: Other substances (food, metals, etc.)
* Sulfa drugs List: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Aspirin 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Local Anesthesia (Novocain) 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Opiates/codeine 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Iodine
* Latex

Type of reactions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. ***Women:*** Are you pregnant or suspect you may be? YES NO If yes, when is your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Name

5. **Past and Present Illness/Symptoms**

Acid-Reflux/Heartburn Yes No Fainting Yes No Liver Disease Yes No

Artificial Heart Valve Yes No Epilepsy/Seizure Disorders Yes No Lung Disease Yes No

AIDS/HIV+ Yes No Glaucoma Yes No Low Blood Pressure Yes No Angina Yes No Heart Attack Yes No Pacemaker Yes No Arthritis Yes No Heart Surgery Yes No Prosthetic valve Yes No Anemia Yes No Heart Murmur Yes No Rheumatic Fever Yes No Asthma Yes No Heart Problems Yes No Smoke/Chew Yes No Bleeding Problems Yes No Hepatitis: Type\_\_\_\_\_ Yes No Surgical Implant Yes No Blood Disorders Yes No High Blood Pressure Yes No Stroke Yes No Bronchitis Yes No Heart or chest pain Yes No Thyroid Problems Yes No Cancer Yes No Headaches or ear pains Yes No TMJ disorder Yes No Chemo/Radiation Thp Yes No Herpes Yes No Tuberculosis Yes No Cosmetic Surgery Yes No Jaundice Yes No Ulcer/Gastritis Yes No Diabetes Yes No Joint Prosthesis Yes No Drug Addiction Yes No Kidney Disease Yes No Emphysema Yes No Stroke Yes No

Do you have any disease, medical condition or problems not listed above? YES NO Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you take anticoagulants / blood thinners? Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever taken bisphosphonates? Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you wear contact lenses? Yes No Explain Have you ever had general anesthesia? Yes No Explain

Do you get short of breath easily? Yes No Explain

**Dental Information**

Date of Last regular dental visit: Month:\_\_\_\_\_\_ Year:\_\_\_\_\_\_ Dentist’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate your ORAL HEALTH in general: ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

How good a job do you feel you are doing in taking care of your oral health?

( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

Are any of your teeth sensitive to: ( ) Hot ( ) Cold ( ) Sweets ( ) Pressure

Are you in dental discomfort today? Yes No Do you clench or grind your teeth? Yes No Are you missing any teeth? Yes No Do your gums bleed when you floss or brush? Yes No Have you ever had orthodontic treatment? Yes No

Do you have dry mouth? Yes No

**Dental History: Mark any that apply**

* Wisdom tooth extraction
* Gum disease (Pyorrhea, Gingivitis or periodontal disease)
* Orthodontics
* Treatment for jaw trauma/fracture (Type?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Had an adverse reaction to dental treatment? Please Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Dental fears or anxiety? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I certify that the above information is complete and accurate. I will inform my dentist of any change in my health and / or medication. Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **MEDICAL HEALTH UPDATE** **Please verify changes in your health status at regular intervals**

Date Change in Health Status Signature

\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_