PATIENT MEDICAL HISTORY

Please print legibly

Salutation:	First Name:		Last Name:		M.I.:
Home Phone:		Cell Phone:	Date of Birth:		
Work Phone:		Fax:		Gender:	
Home Address:			City/State/Zip:		
Employer Name:			Occupation:		
Employer Address:			Social Security:		
Referring Doctor:		Family Dentist:			
Home E-mail:			Work E-mail:		
Insurance Company:		Address:			
Subscriber's Name:		Subscriber's SSN:			
Subscriber's DOB:			Group #:	Relationsh	ip:

Yes	No	Don't
		Know

1. Are you in good health?		
2. Do your gums bleed when you brush?		
3. Have you ever had orthodontic (braces) treatment?		
4. Do you have earaches or neck pains?		
5. Have you had any periodontal (gum) treatments?		
6. Do you wear a removable dental appliance?		
7. Have you had serious trouble with any previous dental treatment? If so, explain:		
8. Have you had head, neck, or jaw injuries?		
	_	
9. Do you have or have you been diagnosed or treated for temporamandibular joint problems (TMJ)?		
10. Do you have any dental problem NOT listed?		
11. Have you had any of the following diseases or problems? Active Tuberculosis?		
Persistent cough greater than a 3 week duration?		
Cough that produces blood?		
12. Has there been any change in your general health in the past year?		
13. Are you now under the care of a physician? If yes, what is/are the condition(s) being		
treated?		
14. Date of last physical exam?		
15. Have you ever had any serious illness, operation, or been hospitalized in the last 5		
years? If so, what was the illness or problem?		
16. Are you taking or have you recently taken any prescription medicine(s)?		
17. Are you taking or have you recently taken any over the counter medicine(s)?		
18. Are you taking or have you recently taken any vitamins, natural or herbal preparations		
and/or diet supplements?		
19. List your physicians:		
Family Physician: Phone:		
Cardiologist: Phone:		
Other: Phone:		
20. Are you on a diet?		
21. Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine),		
Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination?		
22. Do you drink alcoholic beverages?		
If yes, how much did you drink in the last 24 hours?		
If yes, how much did you drink in the past week?		
23. Are you alcohol and/or drug dependent? If yes, have you received treatment?		

24. Do you use drugs or other substances for recreational purposes? If yes, please list:		
Frequency of use (daily, weekly, etc):		
Number of years of recreational drug use:		
25. Do you use tobacco (smoking, snuff, chew)?		
26. Do you wear contact lenses?		

Yes No Don't	Yes
Know	

Are you allergic to or have you had a reaction to?

27. Local anesthetics?		
28. Aspirin?		
29. Penicillin or other antibiotics?		
30. Barbiturates, sedatives, or sleeping pills?		
31. Sulfa drugs?		
32. Codeine or other narcotics?		
33. Latex?		
34. Iodine?		
35. Hay fever/seasonal?		
36. Animals?		
37. Food (specify):		
38. Other (specify):		
39. Metals (specify):		
40. Have you ever had an orthopedic joint (hip, knee, elbow, finger) replacement?		
If yes, when was operation done?		
If yes, have you had any complications or difficulties with prosthetic joint?		
41. Has a physician or previous dentist recommended that you take antibiotics prior to		
your dental treatment?		

For Women Only:

42. Are you or could you be pregnant? Estimated Delivery Date:		
43. Nursing?		
44. Taking birth control pills or hormonal replacement?		

Please indicate if you have had any of the following diseases or problems:

45. Abnormal bleeding?		
46. AIDS or HIV infection?		
47. Anemia/Blood Disorder?		
48. Arthritis/Swollen Ankles/Joint Disease?		
49. Rheumatoid arthritis?		
50. Asthma?		
51. Blood transfusion? If yes, date:		
52. Bruise easily?		
53. Cancer/Chemotherapy/Radiation treatment?		
54. Cardiovascular disease? If yes, specify below:		

	Angina	Irregular heart beat
	Arteriosclerosis	Heart murmur
	Artificial heart valves	Heart surgery
	Congenital heart defects	High blood pressure
	Congestive heart failure	Low blood pressure
	Coronary heart failure	Mitral valve prolapse
	Coronary artery disease	Pacemaker
	Damaged heart valves	Rheumatic heart disease/ Rheumatic fever
	Heart attack	-

Yes	No	Don't
		Know

55. Chest pain upon exertion?			
57. Contagious diseases? Image: Second S			
58. Disease, drug, or radiation-induced immunosurpression? Image: Second Se			
59. Diabetes? Type I (insulin dependent) Type II Image: Second Sec	57. Contagious diseases?		
60. Dry mouth? 1 61. Eating disorders? If yes, specify: 1 62. Epilepsy? 1 63. Fainting spells or seizures? 1 64. Gastrointestinal disease? 1 65. G.E. Reflux/persistent heartburn? 1 66. Glaucoma/Eye Disease? 1 67. Healing delay? 1 68. Hemophilia? 1 69. Hepatitis, jaundice, or liver disease? 1 70. Recurrent infections? If yes, specify: 1 71. Kidney problems or dialysis? 1 72. Low blood sugar? 1 73. Mental health disorders? If yes, specify: 1 74. Malnutrition? 1 75. Night sweats or Chronic fatigue? 1 76. Neurological disorders? If yes, specify: 1 77. Osteoporosis? 1 78. Persistent swollen glands in neck? 1 79. Respiratory problems? If yes, specify: 1 80. Severe headaches/migraines? 1 81. Severe or rapid weight loss? 1 82. Sexually transmitted disease? 1 83. Sinus trouble? 1 84. Sleep disorder? 1 <	58. Disease, drug, or radiation-induced immunosurpression?		
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If this visit is related to an injury, fill out the fields below:

□ Accident related	□ Work related
Date of Injury:	
Insurance Company Handling Claim:	Claim Number:
Name of Attorney / Adjustor:	Attorney / Adjustor Telephone #: