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 #:	Relationship:

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

	Yes	No	Don't Know
55. Chest pain upon exertion?			
56. Chronic pain?			
57. Contagious diseases?			
58. Disease, drug, or radiation-induced immunosurpression?			
59. Diabetes? ☐ Type I (insulin dependent) ☐ Type II			
60. Dry mouth?			
61. Eating disorders? If yes, specify:			
62. Epilepsy?			
63. Fainting spells or seizures?			
64. Gastrointestinal disease?			
65. G.E. Reflux/persistent heartburn?			
66. Glaucoma/Eye Disease?			
67. Healing delay?			
68. Hemophilia?			
69. Hepatitis, jaundice, or liver disease?			
70. Recurrent infections? If yes, specify:			
71. Kidney problems or dialysis?			
72. Low blood sugar?			
73. Mental health disorders? If yes, specify:			
74. Malnutrition?			
75. Night sweats or Chronic fatigue?			
76. Neurological disorders? If yes, specify:			
77. Osteoporosis?			
78. Persistent swollen glands in neck?			
79. Respiratory problems? If yes, specify:			
80. Severe headaches/migraines?			
81. Severe or rapid weight loss?			
82. Sexually transmitted disease?			
83. Sinus trouble?			
84. Sleep disorder?			
85. Sores or ulcers in mouth?			
86. Stroke?			
87. Systemic lupus erythematosus?			
88. Tuberculosis?			
89. Thyroid problems?			
90. Ulcers/Colitis?			
91. Excessive urination?			
92. Do you have any disease, condition, or problem not listed above that you think the doctor should know about? Please explain:			
93. Are you taking bisphosphonates now or have you taken then in the past (Fosamax)?			

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 #:

_____ _____

Patient Signature (Parent signature if patient is under 18 years of age) **Date**