# MEDICAL HISTORY

*Your dental health relates to your overall health. Medical problems or medications could affect your teeth and gums. So that we may treat you holistically, please complete the following confidential information.*

DATE _____

NAME _____ LAST PHYSICAL _____

PHYSICIAN _____ PHYSICIAN'S PHONE _____

| NO | YES | |
|---|---|---|
| ☐ | ☐ | Are you currently under a physician's care? _____ |
| ☐ | ☐ | Do you require antibiotic premedication prior to dental treatment? _____ |
| ☐ | ☐ | Do you have any alcohol or drug related problems? _____ |
| ☐ | ☐ | Do you smoke or chew tobacco? How much? _____ |
| ☐ | ☐ | Do you presently or have you ever taken medication for osteoporosis? (e.g. Fosamax) |
| ☐ | ☐ | Are you currently taking medications? List name and dosage. |
| | | _____ |
| ☐ | ☐ | Do you have any diseases, conditions or problems not mentioned? Explain. |
| | | _____ |

| ALLERGIC REACTIONS | NO | YES |
|---|---|---|
| Analgesics | ☐ | ☐ |
| Anesthetics | ☐ | ☐ |
| Antibiotics | ☐ | ☐ |
| Latex | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

| CARDIOVASCULAR | NO | YES |
|---|---|---|
| Angina Pectoris | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ |
| Congenital Heart Disease | ☐ | ☐ |
| Fainting or Dizzy Spells | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Heart Trouble | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ |

| ENDOCRINE | NO | YES |
|---|---|---|
| Diabetes | ☐ | ☐ |
| Thyroid Problems | ☐ | ☐ |

| GENITOURINARY | NO | YES |
|---|---|---|
| Bladder Trouble | ☐ | ☐ |
| Kidney Trouble | ☐ | ☐ |
| Venereal Disease | ☐ | ☐ |

| MUSCULOSKETAL | NO | YES |
|---|---|---|
| Arthritis / Rheumatism | ☐ | ☐ |
| Back Problems | ☐ | ☐ |

| GASTROINTESTINAL | NO | YES |
|---|---|---|
| Hepatitis A / B / C | ☐ | ☐ |
| Liver Disease or Jaundice | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Weight Loss or Gain | ☐ | ☐ |

| RESPIRATORY | NO | YES |
|---|---|---|
| Allergies or Hives | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Hay Fever | ☐ | ☐ |
| Pneumonia | ☐ | ☐ |
| Sinus Trouble | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |

| NEUROLOGIC | NO | YES |
|---|---|---|
| Anxiety Problems | ☐ | ☐ |
| Epilepsy or Seizures | ☐ | ☐ |
| Parkinson's Disease | ☐ | ☐ |
| Psychiatric Care | ☐ | ☐ |

| HEMATOLOGIC | NO | YES |
|---|---|---|
| Blood Transfusions | ☐ | ☐ |
| Bruise or Bleed Easily | ☐ | ☐ |
| Hemophilia | ☐ | ☐ |
| Leukemia | ☐ | ☐ |
| Sickle Cell Anemia | ☐ | ☐ |

| IMMUNOLOGIC | NO | YES |
|---|---|---|
| AIDS | ☐ | ☐ |
| HIV Positive | ☐ | ☐ |
| Night Sweats | ☐ | ☐ |
| Skin Disease | ☐ | ☐ |

| SPECIAL SENSES | NO | YES |
|---|---|---|
| Contact Lenses | ☐ | ☐ |
| Ear Problems | ☐ | ☐ |
| Eye Problems | ☐ | ☐ |
| Smell or Taste Problems | ☐ | ☐ |

| SURGERY | NO | YES |
|---|---|---|
| Artificial Joints | ☐ | ☐ |
| Cancer or Tumors | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ |
| Operation in Past 5 Years | ☐ | ☐ |
| Organ Transplant | ☐ | ☐ |
| Radiation Therapy | ☐ | ☐ |

| WOMEN | NO | YES |
|---|---|---|
| Birth Control Pills | ☐ | ☐ |
| Nursing | ☐ | ☐ |
| Pregnant or Lactating | ☐ | ☐ |

| FACIAL PAIN HISTORY | NO | YES |
|---|---|---|
| Facial or Neck Pain | ☐ | ☐ |
| Headaches or Migraines | ☐ | ☐ |
| Jaw Noise or Pain | ☐ | ☐ |
| Pain upon Chewing | ☐ | ☐ |
| Injury to Head or Neck | ☐ | ☐ |

***I accurately answered these questions. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you.***

PATIENTS'S SIGNATURE DOCTOR'S SIGNATURE