Patient Medical History

Physician_____ **Office Phone**_____ **Date of Last Exam**_____

Are you under a physician's care now?	**Yes**	**No**	**If yes, please explain:**_____
Have you recently been hospitalized?	**Yes**	**No**	**If yes, please explain:**_____
Are you taking any medications, pills, or drugs?	**Yes**	**No**	**Please list drugs and reason for use below:**
Have there been changes in your health this year?	**Yes**	**No**	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	**Yes**	**No**	
Are you on a special diet?	**Yes**	**No**	
Do you use tobacco?	**Yes**	**No**	
Do you use controlled substances?	**Yes**	**No**	

Women: Are you:

Pregnant/Trying to get pregnant? **Yes** **No** **Taking oral contraceptives?** **Yes** **No** **Nursing?** **Yes** **No**

Are you allergic to any of the following?

Aspirin **Penicillin** **Codeine** **Local Anesthetics** **Acrylic** **Metal** **Latex** **Sulfa drugs**

Other **If yes, please explain:**_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	**Yes**	**No**	**Diabetes**	**Yes**	**No**	**High Cholesterol**	**Yes**	**No**	**Recent Weight Loss**	**Yes**	**No**
Alzheimer's Disease	**Yes**	**No**	**Drug Addiction**	**Yes**	**No**	**Hives or Rash**	**Yes**	**No**	**Renal Dialysis**	**Yes**	**No**
Anaphylaxis	**Yes**	**No**	**Easily Winded**	**Yes**	**No**	**Hypoglycemia**	**Yes**	**No**	**Rheumatic Fever**	**Yes**	**No**
Anemia	**Yes**	**No**	**Emphysema**	**Yes**	**No**	**Irregular Heartbeat**	**Yes**	**No**	**Rheumatism**	**Yes**	**No**
Arthritis/Gout	**Yes**	**No**	**Epilepsy or Seizures**	**Yes**	**No**	**Jaundice**	**Yes**	**No**	**Scarlet Fever**	**Yes**	**No**
Artificial Heart Valve	**Yes**	**No**	**Excessive Bleeding**	**Yes**	**No**	**Kidney Problems**	**Yes**	**No**	**Shingles**	**Yes**	**No**
Artificial Joint	**Yes**	**No**	**Excessive Thirst**	**Yes**	**No**	**Leukemia**	**Yes**	**No**	**Sickle Cell Disease**	**Yes**	**No**
Aspirin Therapy	**Yes**	**No**	**Fainting Spells/Dizziness**	**Yes**	**No**	**Liver Disease**	**Yes**	**No**	**Sinus Trouble**	**Yes**	**No**
Asthma	**Yes**	**No**	**Fatigue/Exhaustion**	**Yes**	**No**	**Low Blood Pressure**	**Yes**	**No**	**Spina Bifida**	**Yes**	**No**
Blood Thinners	**Yes**	**No**	**Frequent Cough**	**Yes**	**No**	**Lung Disease**	**Yes**	**No**	**Stomach/Intestinal Disease**	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	**Frequent Headaches**	**Yes**	**No**	**MAOI Inhibitors**	**Yes**	**No**	**Stroke**	**Yes**	**No**
Breathing Problem	**Yes**	**No**	**Glaucoma**	**Yes**	**No**	**Mitral Valve Prolapse**	**Yes**	**No**	**Swelling of Limbs**	**Yes**	**No**
Bruise Easily	**Yes**	**No**	**Hay Fever**	**Yes**	**No**	**Motion Sickness**	**Yes**	**No**	**Swollen Glands**	**Yes**	**No**
Cancer	**Yes**	**No**	**Heart Attack/Failure**	**Yes**	**No**	**Organ Transplant**	**Yes**	**No**	**Thyroid Disease**	**Yes**	**No**
Chemotherapy	**Yes**	**No**	**Heart Murmur**	**Yes**	**No**	**Osteoporosis**	**Yes**	**No**	**Tonsillitis**	**Yes**	**No**
Chest Pains	**Yes**	**No**	**Heart Trouble/Disease**	**Yes**	**No**	**Pacemaker/Defibrillator**	**Yes**	**No**	**Tricyclic Antidepressants**	**Yes**	**No**
Cold Sores/Fever Blisters	**Yes**	**No**	**Hepatitis A,B or C**	**Yes**	**No**	**Parathyroid Disease**	**Yes**	**No**	**Tuberculosis**	**Yes**	**No**
Congenital Heart Disorder	**Yes**	**No**	**Herpes**	**Yes**	**No**	**Psychiatric Care**	**Yes**	**No**	**Tumors or Growths**	**Yes**	**No**
Convulsions	**Yes**	**No**	**High Blood Pressure**	**Yes**	**No**	**Radiation Treatments**	**Yes**	**No**	**Ulcers**	**Yes**	**No**
									Other:_____		

Patient Dental History

Name of Previous Dentist_____ **Date of Last Exam**_____

Previous Dentist's Location_____ **Date of Last Cleaning**_____

	Yes	**No**
1. Do your gums bleed while brushing or flossing?	___	___
2. Are your teeth sensitive?	___	___
3. Are you troubled with bad breath?	___	___
4. Do you feel pain to any of your teeth?	___	___
5. Do you have any sores or lumps in or near your mouth?	___	___
6. History of any periodontal therapy?	___	___
7. Do you like your smile?	___	___
8. Do you snore or have you been told that you snore?	___	___
9. How do you feel about the possibility of losing your teeth?	___	___
10. Have you had any head, neck or jaw injuries?	___	___
11. Has fear or discomfort kept you from regular visits?	___	___
12. Have you ever had any difficult extractions in the past?	___	___
13. Have you had any orthodontic treatment?	___	___
14. Have you ever had any prolonged bleeding following extractions?	___	___
15. Do you wear dentures or partials?	___	___
If yes, date of placement_____		
16. Do you have frequent headaches?	___	___
17. Do you clench or grind your teeth?	___	___
18. Have you ever experienced any of the following problems in your jaw?		
Clicking, popping	___	___
Pain (joint, ear, side of face)	___	___
Difficulty in opening or closing	___	___
Difficulty in chewing food	___	___
19. History of Anorexia or Bulimia	___	___

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____**DATE**_____