

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____ Phone # _____

Most recent physical examination _____ Purpose _____

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.
 Have you had any of the following diseases or problems?

	Yes	No
Active Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>

What is your estimate of your general health? Poor _____ Fair _____ Good _____

Has there been any change in your general health within the past year? _____

What medicines are you taking? Prescribed _____

Over the counter: _____

Vitamins, natural or herbal preparation and/or diet supplements: _____

Answer yes or no to the following questions:	Yes	No		Yes	No
Have you had an allergic reaction to?			Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>
aspirin, ibuprofen,	<input type="checkbox"/>	<input type="checkbox"/>	GE Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>
penicillin or other antibiotic	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
codeine or other narcotic	<input type="checkbox"/>	<input type="checkbox"/>	Head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
fluoride	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>
metals (gold, stainless steel)	<input type="checkbox"/>	<input type="checkbox"/>	Hives, skin, rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
latex	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections	<input type="checkbox"/>	<input type="checkbox"/>
any other medications _____			Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had the following?			Mental health disorders, if yes specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Migraines or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders, if yes specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (or Rheumatoid arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial prosthesis (heart valve or joints)	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands of neck	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date _____			Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion, if yes what date? _____	<input type="checkbox"/>	<input type="checkbox"/>	Sores or ulcers in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease, if yes specify below	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus	<input type="checkbox"/>	<input type="checkbox"/>
____ Angina			Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
____ Arteriosclerosis			Tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
____ Congenital heart defect			Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
____ Congestive heart failure			Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>
____ Damaged heart valves			Viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
____ Coronary artery disease			Other condition that we should be aware of		
____ Heart Attack			_____		

Chest Pain on exertion	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Disease, drug, or radiation-induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes ____ Type I insulin dependent, ____ Type II	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder or malnutrition	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY

Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills or hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Remarks: _____

Doctor's Signature _____

DENTAL HISTORY

Referred by _____ Today's Date _____

Previous Dentist _____ How long _____

Most Recent Dental Exam _____ Most Recent Dental X-ray _____

Most Recent Dental Treatment _____

How often do you have your teeth cleaned? 3mo____ 4mo____ 6mo____ 1 year or longer____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
Are you unhappy with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear removable dental appliances?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an unfavorable dental experience?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any dental fears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble getting numb?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an unpleasant taste or odor in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry mouth, throat or eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have jaw problems (temporomandibular joint)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty opening your mouth widely?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have stiff neck muscles?	<input type="checkbox"/>	<input type="checkbox"/>
Do you awaken with an awareness of your teeth or jaws?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have tension headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw click or pop?	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost any teeth?	<input type="checkbox"/>	<input type="checkbox"/>

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check Yes or No)
<input type="checkbox"/>	<input type="checkbox"/>	Has your present denture been relined? When _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your present denture a problem? Describe _____
<input type="checkbox"/>	<input type="checkbox"/>	Satisfied with the appearance? _____
<input type="checkbox"/>	<input type="checkbox"/>	Satisfied with the comfort? _____
<input type="checkbox"/>	<input type="checkbox"/>	Satisfied with the chewing ability? _____
<input type="checkbox"/>	<input type="checkbox"/>	When did you receive your first partial or complete denture? _____
<input type="checkbox"/>	<input type="checkbox"/>	How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Doctor's Signature _____