



Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	YES	NO		YES	NO
1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	6. Do you have or have you had any of the following?		
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____			Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s), including non-prescription medicine?.....	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you allergic to or have you had any reactions to the following:			Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>
Other (please List) _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
7. WOMEN ONLY:			Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of last Exam _____

1. Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	5. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	7. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever experienced any of the following problems in your jaw					
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>			
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>			