

Medical History

Patient's Last Name _____ First _____ MI _____ Birthdate _____

1. Physician's Name _____
 Address _____
 Phone Number _____
2. Are you under a doctor's care now Yes No
 Why? _____
3. Are you pregnant? Yes No
4. Do you use tobacco products? Yes No
 Type and frequency _____
5. Are you allergic to, or have you experienced adverse reactions to:
- | | |
|--|--|
| <input type="checkbox"/> Penicillin/Erythromycin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Metals/Latex Rubber |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other _____ |
6. Are you taking any prescription or non-prescription medications?
- | | |
|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Blood thinner/anticoagulants | <input type="checkbox"/> Insulin (Diabetic Drug) |
| <input type="checkbox"/> Blood Pressure Medications | <input type="checkbox"/> Cortisone/Steroid |
| <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Antihistamine/Allergy Drugs |
| <input type="checkbox"/> Heart Medications | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Diuretics (water pills) | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Sedatives/Tranquilizers | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Antidepressants | |

Doctor Notes

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

7. Have you ever had or have any of the following
- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Chest Pain (Angina) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> HIV+/AIDS |
| <input type="checkbox"/> Swelling Hands, Feet, Ankles | <input type="checkbox"/> Blood Clotting Disorder | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Drug/Alcohol Addiction |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cancer | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Herpes |

8. Have you ever had any surgeries or other serious illness not listed above? Yes No
 If so, what? _____

Patient Signature _____ Date _____

BP Pulse	Updates

Dental History

1. Do you have specific dental problems? Yes No

Describe: _____

2. Would you describe your present dental health as good? Yes No

3. Are you happy with the appearance of your teeth? Yes No

4. Do you brush and floss on a routine basis? Yes No

5. Do you want to keep your remaining teeth? Yes No

6. Do your gums ever bleed? Yes No

7. Do you experience unpleasant taste/bad breath? Yes No

8. Do you have any sensitive teeth at this time? Yes No

9. Have you ever had gum treatment or surgery? Yes No

10. Do you feel unusually nervous about having treatment? Yes No

11. Have you ever had any problems or complications with previous dental treatment or local anesthetic? Yes No

If YES, explain: _____

12. What is the name of your previous Dentist? And date of last visit?

13. Have you ever had orthodontic treatment (Braces)? Yes No

14. Do you ever clench or grind your teeth or have a sense of facial muscle fatigue? Yes No

15. Do you have frequent headaches, shoulder aches or ear aches that are not caused by infection? Yes No

16. Do you have a history of facial/jaw trauma or surgery? Yes No

16. Have you experienced pain, clicking, popping or grating noises in the joints of your jaw when you open, close or chew? Yes No

18. Have you experienced difficulty opening your mouth wider than the width of two fingers without pain or strain? Yes No

19. Have you ever worn a nightguard or a splint? Yes No

20. Do you have any discolored teeth or spaces? Yes No

If YES, describe: _____

21. Do you have any special concerns? Yes No

Discuss: _____

Doctor Notes