PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Have you ever been treated for or been told by a doctor you have or had any of the following:

Rheumatic Fever:	YES / NO	Hypotension (low BP):	YES / NO	Heart Valve Prosthesis:	YES / NO
Diabetes:	YES / NO	Venereal Disease:	YES / NO	Cerebrovascular Accident:	YES / NO
Hepatitis:	YES / NO	Nervous System Disorders:	YES / NO	(stroke)	
Jaundice/Liver Disease:	YES / NO	(seizures, epilepsy, cerebral palsy)		Coronary Artery Disease:	YES / NO
Herpes Virus:	YES / NO	Allergies:	YES / NO	Blood Disorders:	YES/NO
Kidney Disease/Surgery:	YES / NO	(hayfever, medications, food?)		(anemia, leukemia, bleeder)	
Arthritis, Rheumatism:	YES / NO	Unusual Reaction to:	YES / NO	Tuberculosis:	YES/NO
HIV Positive:	YES / NO	(novocain, penicillin, others?)		Positive TB test:	YES/NO
Thyroid Disorder:	YES / NO	Respiratory Disorders:	YES / NO	Gastrointestinal Issues:	YES / NO
Glaucoma:	YES / NO	(asthma, bronchitis)		Prosthetic Devices:	YES / NO
Alcohol/Drug Abuse:	YES / NO	Congenital Heart Disease):	YES / NO	(artificial appliance)	
Cancer:	YES/ NO	(heart murmur)			
Hypertension (high BP):	YES / NO	Cardiac/Valvular Surgery:	YES / NO		

WOMEN: Are you pregnant? YES / NO If so, what trimester? _____

Briefly explain all YES answers:

_____

_____

Have you ever experienced any of the following:

Swelling of ankles:	YES / NO	Hives, Rash:	YES / NO	Shortness of breath after mild exercise:	YES / NO
Bruise Easily:	YES / NO	Slow Healing:	YES / NO	Frequent Urination (more than 6x/day):	YES / NO
Prolonged Bleeding:	YES / NO	Frequent Dry Mouth:	YES / NO	Frequent Thirst:	YES / NO
Frequent Headaches:	YES / NO	Pain, Pressure, tightness in the		Unintentional weight gain or loss:	YES / NO
Dizziness, Fainting:	YES / NO	chest upon exertion	YES / NO	Shortness of Breath when lying down:	YES / NO
Persistent Cough:	YES / NO			Do you have a Pacemaker?	YES / NO

Briefly explain all YES answers:

_____

_____

Are you currently taking any medication? Including aspirin, vitamins, birth control pills:

Medication Name	Daily Dosage	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DENTAL HISTORY

Why do you seek dental treatment? _____

What do you consider the condition of your oral health? _____

When was your last dental visit? _____What was done? _____

Have you ever had:		**Do you have any oral habits such as:**	
Orthodontic Treatment (braces):	YES / NO	Grinding or clenching your teeth	YES / NO
Periodontic Treatment (gum treatment):	YES / NO	Biting your nails	YES / NO
Restorative Treatment (fillings):	YES / NO	Biting your cheeks	YES / NO
Pedodontic Treatment (children):	YES / NO	Sucking your tongue, fingers or lips	YES / NO
Endodontic Treatment (root canal	YES / NO	Chewing pencils or other object	YES / NO
Prosthodontic Treatment (partials, bridgework)	YES / NO	Smoking	YES / NO
Have you ever taken fluoride tablets or drops?	YES / NO	Chewing Tobacco	YES / NO
Have you ever received fluoride treatments?	YES / NO	Do your gums bleed while flossing?	YES / NO
Do you use fluoride toothpaste regularly?	YES / NO	Do you avoid brushing or flossing any part due to pain?	YES/NO

Do you use any of the following: Water Pik ____ Stim-u-dents ____ Perio Aid ____ Floss ____ Toothpick ____ Other _____

Do you chew only one side of your mouth? YES / NO If so, please explain:

_____

Have you ever had local anesthesia (Novocain, xylocaine, etc)? YES / NO

If so, did you experience any adverse reactions? _____

Signature: _____ Today's Date: _____