MEDICAL HISTORY

Patient Name _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Describe your physical health ☐Excellent ☐Good ☐Fair ☐Poor Last Physical _____

Physician's Name _____ Phone Number _____

Have you had any surgeries? Yes No Please explain _____

Please list all prescribed and over-the-counter medications or supplements you take _____

_____

Do you consider yourself under an abnormally high amount of stress Yes No Do you sleep well? Yes No

Do you exercise regularly? Yes No Have you had nutritional deficiencies? Yes No

Sex: ☐

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height: ☐
		For Office Use Only	Weight: ☐
		BP ☐ Heart Rate: ☐	

Y	N	Conditions
☐	☐	Artificial Heart Valve
☐	☐	Congenital Heart Defect
☐	☐	Heart Murmur With Regurgitation
☐	☐	Mitral Valve Prolapse
☐	☐	Angina Pectoris
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Pace Maker
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	High Cholesterol
☐	☐	Congestive Heart Failure
☐	☐	Stroke
☐	☐	Artifical Joints
☐	☐	Arthritis, Type _____
☐	☐	HIV+/AIDS
☐	☐	Hepatitis, Type _____
☐	☐	Tuberculosis
☐	☐	Cold Sores/Herpes
☐	☐	Blood Transfusion
☐	☐	STD, Type _____
☐	☐	Shingles

Y	N	Conditions
☐	☐	Asthma
☐	☐	Difficulty Breathing
☐	☐	Emphysema
☐	☐	Diabetes, Type _____
☐	☐	Hypoglycemia
☐	☐	Allergies, Type, Rxn _____
☐	☐	Hay Fever
☐	☐	Cancer, Type _____
☐	☐	Tumors Or Growths
☐	☐	Chemotherapy
☐	☐	Radiation Therapy
☐	☐	Drug/Alcohol Dependency
☐	☐	Psychiatric Care
☐	☐	Depression
☐	☐	Anxiety
☐	☐	ADHD
☐	☐	Alzheimer's Disease
☐	☐	Dementia
☐	☐	Epilepsy
☐	☐	Seizures
☐	☐	Abnormal/Excessive Bleeding
☐	☐	Blood Disease, Type _____

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Frequent Cough
☐	☐	Acid Reflux
☐	☐	Any Surgeries?
☐	☐	Hospitalized For Any Reason
☐	☐	Systemic Disease, See Below

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Please specify (✓) type(s) of systemic disease(s):

☐Heart Disease ☐Kidney Disease/Problems ☐Liver Disease/Problems ☐Parathyroid Disease
☐Lung Disease ☐Renal Dialysis ☐Yellow Jaundice ☐Hypothyroidism
☐Anemia ☐Stomach Disease ☐Sinus Troubles ☐Hyperthyroidism
☐Sickle Cell Disease ☐Intestinal Disease ☐Tonsillitis ☐Multiple Sclerosis
☐Spina Bifida ☐Ulcers ☐Other _____

Please check (✓) if you have had problems with the following

☐Frequent Headaches ☐Ear Pain ☐Jaw Pain ☐Throat Pain
☐Neck Aches ☐Hearing Changes ☐Jaw Noises ☐Dizziness
☐Back Pain ☐Ear/Sinus Congestion ☐Jaw Locking ☐Fatigue
☐Shoulder Pain ☐Ear/Sinus Pain ☐Difficulty Eating ☐Eye Pain
☐Swelling ☐Ringing Ears ☐Difficulty Sleeping ☐Visual Symptoms
☐Muscle Spasms ☐Other _____

The above information in my dental and medical histories is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions I may have made in the completion of this form.

Date _____ Signature _____

(Parent or Guardian if under age 18)