MEDICAL HISTORY FORM

NAME: ____ Date: __________________________

Date of Birth: ____/____/________ Height: _______________ Weight:____________________

1. Are you in good health? ………………………………………………………………..Yes No
2. Has there been any change in your general health within the past year? ……………………... Yes No
3. My last physical examination was on ____
4. Are you now under the care of a physician? ……………………………………………………...Yes No

   If so, what is the condition being treated? ____

5. The name and address of my physician is ____

   ____

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ………………………………………… Yes No
7. Are you taking any medication(s), including, weight loss medications and/or non-prescription medications? ………………… Yes No

   If so, please list: ____

8. Are you allergic to any medications? ____
9. Do you have or have you had any of the following diseases or problems?

   a. Damaged or artificial heart valves, including heart murmur or rheumatic heart disease? ……….................................Yes No

   b. Heart trouble (high blood pressure, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke) ………...Yes No

   c. Allergies or hay fever………………………………………………………………………….............................Yes No

   d. Sinus trouble……………………………………………………………………………………………………...Yes No

   e. Asthma………………………………………………………………………………..Yes No

   f. Fainting spells or seizures…………………………………………………………………………………...Yes No

   g. Diabetes………………………………………………………………………………………..............................Yes No

   h. Hepatitis, jaundice, or liver disease……………………………………………………………………….........Yes No

   i. AIDS or HIV infection……………………………………………………………………………………….........Yes No

   j. Thyroid problems……………………………………………………………………………………………………Yes No

   k. Respiratory problems, emphysema, bronchitis, etc………………………………………………………….........Yes No

   l. Arthritis or painful swollen joints……………………………………………………………………….......Yes No

   m. Kidney trouble……………………………………………………………………………………………………...Yes No

   n. Tuberculosis…………………………………………………………………………………………………….......Yes No

   o. Low blood pressure………………………………………………………………………………………….........Yes No

   p. Sexually transmitted disease……………………………………………………………………………………..Yes No

   q. Problems with mental health…………………………………………………………………………………..Yes No

   r. Cancer……………………………………………………………………………………….............................Yes No

   s. Artificial joints…………………………………………………………………………………………………......Yes No

10. Do you smoke? Yes No If so, how many packs per day? ______________________________

WOMEN: Is there any possibility of pregnancy? ______________ Are you nursing? ______________ Are you taking birth control pills? ______________

Do your gums bleed while brushing or flossing? Yes No
Are you teeth sensitive to hot or cold liquids? Yes No
Do you feel pain to any of your teeth? Yes No
Do you have sores/lumps in or near your mouth? Yes No
Have you had any head, neck, or jaw injuries? Yes No
Have you ever experienced any of the following? (circle)
Clicking Difficulty opening/ closing
Pain (ear, side of face, joint) Difficulty chewing

Do you have frequent headaches? Yes No
Do you clench or grind you teeth? Yes No
Do you bite your cheeks or lips frequently? Yes No
Have you had any orthodontic work? Yes No
Have you had difficult extractions in the past? Yes No
Have you ever had instruction on the correct care of teeth and gums? Yes No

Patient Signature: _________________________________ Doctor Signature: _______________________