Medical History

Patient's Name _____ Date of Birth _____/_____/_____

Gender: Male / Female Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No

If yes, please describe: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?_____

PATIENT MEDICAL HISTORY

Do you have or have you ever had: (Please Specify)

Cardiovascular disease (heart attack/murmur/surgery), high Cholesterol, Congenital heart disease, coronary artery disease, chest pain, stroke, irregular heartbeat, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
High Blood Pressure	Yes	No	Frequent headaches or migraines?	Yes	No
Implants or joint replacements placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Have you ever been told to take pre medication?	Yes	No	ADD/ADHD	Yes	No
Do you have sleep apnea?	Yes	No	Do you use a C PAP Machine?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease? (Hypo/ Hyper)	Yes	No	Diabetes? Type 1 or Type 2	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
GERD or Acid Reflux Disease	Yes	No	Significant weight loss or gain?	Yes	No
Mental health disorders?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Sexually transmitted disease?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No

If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

FEMALE PATIENTS Are you pregnant, or is there any chance you might be pregnant? Yes No

How many weeks? _____ Are you nursing? _____

MEDICATIONS(Please Specify)

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Diabetic medication?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Bisphosphonates, antiangiogenic and/or anti-resorptive medications for osteoporosis, multiple myeloma or other	Yes	No
Anti-anxiety, sedative-hypnotics and antidepressants medications?	Yes	No	cancers? If yes, list drugs used and time of use. _____ _____		
Prescription pain medication?	Yes	No			

Please list **ALL** medications you have taken or are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:_____
_____
_____

ALLERGIES

Are you allergic to or have you had an adverse reaction to: (Please Specify)

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No
Sulfa Drugs?	Yes	No	Tylenol 3?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____
Other drug allergies not listed above: _____

SOCIAL HISTORY

Do you use tobacco (smoke, snuff, chew, bidis, electronic cig)? Yes No
Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:			**Do you use:**			
Drug abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY (Please Specify)

Have you had any adverse effects from dental treatment?	Yes	No	If Yes, please explain?_____		
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Frequent or recurring mouth sores?	Yes	No
Do your gums bleed when you brush or floss?	Yes	No	Are your teeth sensitive to hot, cold or sweets?	Yes	No
Is your mouth dry?	Yes	No	Have you ever had periodontal (gum) treatment?	Yes	No
Have you ever had orthodontic (braces) treatment?	Yes	No	Do you clench or grind your teeth?	Yes	No
Have you ever had a serious injury to the head?	Yes	No	Are you experiencing any dental pain?	Yes	No

Do you have any Dental concerns? _____

Date of your last dental visit: _____ What was done?_____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____ _____ _____
Signature of patient, parent, guardian Printed name of patient, parent, guardian/Relationship Date