MEDICAL HISTORY

Patient's Name:_____ Age:_____ Chart #:_____

1. Is patient in good health? Yes__ No__ If No, explain_____

2. Physician's Name:_____ Phone Number:_____

Is patient under a physicians care now? Yes__ No __ If Yes,explain_____

3. Is patient taking prescribed or any over the counter medication? Birth control medications? Yes__ No__

If Yes, list medications:_____

4. Is the patient pregnant? Yes__ No__ If Yes, how many months? ____

5. Has patient taken any weight loss medications? (e.g. PhenFen) Yes__ No__

6. Has patient ever had a blood transfusion? Yes__ No__

7. Does the patient smoke? Yes__ No__ Use tobacco? Yes__ No__ Use recreational drugs? Yes__ No__

8. Does the patient use alcohol? Yes__ No__ If yes, how often? _____

9. Has the patient ever had a allergic reaction to local anesthetic (e.g novacaine)? Yes__ No__

10. Is the patient allergic to any medication (e.g. penicillin)? Yes__ No__

11. Has the patient ever had a skin reaction to metals or jewelry? Yes__ No__

12. Is the patient allergic to latex? Yes__ No__

13. Has the patient ever had prolonged bleeding after an injury or extraction? Yes__ No__

14.. Does the patient have a cardiac pacemaker or artificial heart valve? Yes__ No__

15. Is there any family history of diabetes, heart murmur/problems, tumors? Yes__ No__

16. Does the patient's jaw pop or click when chewing? (TMJ) Yes__ No__

17. Are you pleased with the appearance of your smile? Yes__ No__

If no, explain_____

18. What would you like to discuss with the dentist today? (Check all that applied)

__Tooth Ache __Oral Surgery __Partials/Dentures __Cosmetic Dentistry

__Gum Problem __Routine check-up __Removal of Wisdom Teeth __Crowns/Bridges

__Braces __Second Opinion __Replace missing teeth __Other _____

19. Does the patient have any missing teeth? Yes__ No__ If yes, does the patient have an appliance? Yes__ No__

What type?_____ Year made_____ Is it comfortable? Yes__ No__

20. Please check each box, yes or no, if the patient has ever had any illness or conditions listed below. Please do not leave it blank.

Yes No	Yes No	Yes No	Yes No
__ __ AIDS/HIV	__ __ Allergies	__ __ Anemia	__ __ Angina
__ __ Arthritis	__ __ Artificial Joint	__ __ Asthma	__ __ Bleeding Disorders
__ __ Cancer	__ __ Chemotherapy	__ __ Cold Sores	__ __ Diabetes
__ __ Dizzy Spells	__ __ Emphysema	__ __ Epilepsy	__ __ Emotional Disorder
__ __ Fainting	__ __ Fever Blisters	__ __ Glaucoma	__ __ Heart Attack
__ __ Heart Bypass	__ __ Heart Murmur	__ __ Heart Problems	__ __ Heart Surgeries
__ __ Hepatitis	__ __ High Blood Pressure	__ __ HIV Positive	__ __ Immunosuppressed
__ __ Jaundice	__ __ Kidney Disease	__ __ Liver Problems	__ __ Low Blood Pressure
__ __ Lung Disease	__ __ Nervous/Mental Disorder	__ __ Psychiatric Treatment	__ __ Radiation Therapy
__ __ Rheumatic Fever	__ __ Sinus Trouble	__ __ Stroke	__ __ Thyroid Problem
__ __ Tuberculosis	__ __ Venereal Disease		

21. Has patient had any disease, serious illness/surgery, condition or problem not listed above. Yes __ No __. If Yes, explain_____

22. Has patient been on any IV Biophosphonates or Oral Biophosphonates in the last 5 years? Yes__No__ If Yes, explain_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

Patient's Signature/responsible party if patient is a minor_____ Date_____

For Doctors Use Only

Health History Reviewed By _____(Doctor's Signature) Date_____

Comments: