Patient Medical History

Salutation:	First Name:	Last Name:	M.I.:
Home Phone: ( )	Cell Phone: ( )	Date of Birth:	
Work Phone: ( )	Fax: ( )	Gender:	
Home Address:		City/State/Zip:	
Employer Name:		Occupation:	
Employer Address:		Social Security Number:	
Referring Doctor:		Family Dentist:	
Family Physician:		Family Physician Phone: ( )	
Guarantor:		Date of Last Physical Exam: / /	
Home E-mail:		Work E-mail:	
Insurance Company:		Address:	
Subscriber Name:		Subscriber Social Security Number:	
Subscriber DOB:	Group #:	Relationship:	

	Yes	No	Unknown
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain:			
2. Has there been any change in your general health within the past year? If yes, please explain:			
3. Are you under the care of a physician for a current problem? If yes, please explain:			
4. Have you been hospitalized within the past 5 years? Please specify:			
5. Have you received any therapy for alcoholism or drug addiction during the past 5 years?			
6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications? If yes, please specify:			
7. Is there any condition concerning your health that the doctor should be told?			
8. Do you wish to speak to the doctor privately about anything?			
9. Have you ever had abnormal bleeding with previous extraction's, surgery, or trauma?			
10. Have you ever required a blood transfusion?			
11. Have you ever had radiation for any condition?			
12. Have you ever tested positively for HIV infection or AIDS? If so state date diagnosed and treating doctor:			
13. Before a dental appointment are you required to take premedication? If so, why:			

14. Do you have or have you had any of the following?

- ☐ High blood pressure
- ☐ Hear murmur or prolapsed valve
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Cardiovascular disease: heart attack, stroke or bypass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g. anemia)
- ☐ Venereal disease
- ☐ Asthma
- ☐ Allergy to latex
- ☐ Low blood pressure
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcer, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Low blood sugar
- ☐ Dialysis

☐	Chest pain, angina	☐	Irregular heart beat
☐	Swollen ankles, arthritis or joint disease	☐	Contagious diseases
☐	Cardiac pacemaker	☐	Bronchitis, chronic cough
☐	Heart surgery	☐	Hay fever or sinus problems
☐	Delay in healing	☐	Problems with immune system
☐	Tuberculosis	☐	Difficult breathing or other lung trouble
☐	Emphysema	☐	Chronic fatigue or night sweats
☐	X-ray treatment or chemotherapy	☐	History of drug abuse
☐	On a diet	☐	Wear contact lenses
☐	History of alcohol abuse	☐	Bruise easily
☐	Eye disease or glaucoma	☐	Gallbladder trouble
☐	Infectious mononucleosis	☐	None of the above

	Yes	No	Unknown
15. Are you taking any herbal medicine? (i.e., St. John's Wort)?			
16. Have you ever taken the "fen-phen" diet?			
17. Do you have any disease, condition or problem not listed above? Please specify:			
18. Are you taking bisphosphonates now or have you ever taken them on the past? (Fosamax)			

Women only:

Possibility of pregnancy? YES / NO	Nursing? YES / NO
Estimated delivery date? YES / NO	Taking birth control pills? YES / NO

	Yes	No	Unknown
19. Are you taking any medications or drugs?			

Please list any medications:

Medication Prescribed	Reason for Taking	Quantity	Frequency

Emergency Contact Info

Full Name:	Home #: ( )	Cell #: ( )

Signature: ____ Date: ______________________