

MEDICAL HISTORY

Patient's Name	Date of Birth
Current Physicians Name:	
Explain any past hospitalizations or major operations:	
List any current medications (including non-prescription):	
List all allergies (including non-drug):	
If this is your first visit, have you had dental x-rays w/in the past 3 years? If so, where?	
Please check if any of the following conditions apply to you.	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Aids or HIV Infection
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Heart Problems/Surgery	<input type="checkbox"/> Allergies
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Arthritis or Rheumatism
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Joint Replacement or Implant
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> High/ Low Blood Pressure	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Congenital Heart Problem	<input type="checkbox"/> Chemotherapy (Cancer, Leukemia)
<input type="checkbox"/> Swelling of Feet, Ankles, Hands	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Asthma or Hay Fever	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Lung or Breathing Problems	<input type="checkbox"/> Mental Health Care
<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Cortisone Treatment	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Cold Sores/ Fever Blisters	<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Headaches	<input type="checkbox"/> Latex Allergy
<input type="checkbox"/> Pregnant/ Nursing	<input type="checkbox"/> Birth Control Pills
Please answer the following questions only if they apply to you.	
Have you taken Fen-Phen/ Redux?	Do you clench or grind your teeth?
Use tobacco?	Difficulty w/ past extractions?
Use or used controlled substances?	Past periodontal (gum) treatment?
Have you ever taken medication for osteoporosis?	Are any teeth loose?
Do your gums bleed?	Are your teeth sensitive to hot/cold?
Have you had any head, neck, or jaw injuries?	Are your teeth sensitive to sweets?
Do you wear dentures/ partials? If yes, please indicate when they were made.	
If this is your first visit, how did you hear about our office?	
If you would like to receive information via e-mail, please provide your e-mail address:	

I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately and understand that providing incorrect information can be dangerous to my health.

Signature _____ Date _____