MEDICAL HISTORY

NAME_____DOB_____Date_____

Has there been any problem in your general health within the last five years? (serious illness, hospitalization, surgery)
☐Yes ☐No If so, what was the problem? _____

What was the date of your last physical exam by a physician?_____

Does any physician require you to take special medication before dentistry? ☐Yes ☐No If so, what?_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? ☐Yes ☐No
If so, please list_____

Is snoring a problem? ☐Yes ☐No Have you had a sleep study? ☐Yes ☐No

Have you ever had a head or jaw injury? ☐Yes ☐No

Women:

Could you possibly be pregnant? ☐Yes ☐No If yes, how long since the 1st day of last menstrual period? _____

Are you using birth control pills, patch or implants? ☐Yes ☐No Are you nursing? ☐Yes ☐No

Have you taken bisphosphonate medication for osteoporosis or cancer? (Fosomax, Boniva, Actonel) ☐Yes ☐No

Do you have or have you ever had:

I. Eye, ear, nose, throat problems? Sinus? ☐Yes ☐No

II. Skeletal, neck, shoulder, back problems? Arthritis? Artificial joints? ☐Yes ☐No

III. Any heart or vascular disease: circulation, stroke, aneurysm, murmurs, heart surgery, angina, chest pains, MVP, TIA, stents, shunt, pacemaker, high/low blood pressure, fainting? ☐Yes ☐No

IV. Blood disorders/medication: hemophilia, anemia, blood thinners, bruising, clots, transfusion, prolonged bleeding? ☐Yes ☐No

V. Lung disease: asthma, emphysema, bronchitis, pneumonia, TB, chronic/severe cough? ☐Yes ☐No

VI. Stomach/Intestinal problems? Ulcers? ☐Yes ☐No

VII. Kidney or Liver problems? Transplant? ☐Yes ☐No

VIII. Metabolic/systemic disease: diabetes, HIV/AIDS, hepatitis, cancer, tumor, STD, thyroid, allergies, seizures, epilepsy, autoimmune disease or compromised immunity? ☐Yes ☐No

IX. Psychiatric problems, chemical dependency, cognitive disorders, anxiety or depression? ☐Yes ☐ No

X. Cosmetic surgery? Head or neck? ☐Yes ☐No

XI. Surgeries in the last 20 years? ☐Yes ☐No

XII. Headaches? ☐Yes ☐No
Type _____ How often? _____

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

Seemingly unrelated medical conditions past or present can influence dental treatment. Does this questionnaire accurately alert us to any medical condition you have had in this regard? ☐Yes ☐No

Do you have any reason to believe that you are NOT in good health? ☐Yes ☐No

PATIENT SIGNATURE_____DATE _____

Primary Physician's Name _____Specialty_____ Phone_____
Preferred Pharmacy _____Pharmacy Phone _____

What tablets, pills or liquids do you take? (Include aspirin, vitamins, supplements and herbal medications? For what conditions were they prescribed?

DATE	MEDICATION OR SUPPLEMENTS/DOSAGES	PURPOSE