

# PATIENT MEDICAL HISTORY

Please place a mark on "Yes" or "No" to indicate if you have had any of the following:

<p><b>Yes No</b></p> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Fainting/Seizures <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Heart Attack <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> <input type="checkbox"/> Leukemia <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Kidney Diseases <input type="checkbox"/> <input type="checkbox"/> AIDS / HIV infection <input type="checkbox"/> <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<p><b>Yes No</b></p> <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker <input type="checkbox"/> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> <input type="checkbox"/> Angina <input type="checkbox"/> <input type="checkbox"/> Frequently Tired <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Emphysema <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Arthritis/Rheumatism <input type="checkbox"/> <input type="checkbox"/> Joint Replacement <input type="checkbox"/> <input type="checkbox"/> Hepatitis/Jaundice <input type="checkbox"/> <input type="checkbox"/> Sexually Trans. Disease <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles/Ulcers <input type="checkbox"/> <input type="checkbox"/> Chest Pains <input type="checkbox"/> <input type="checkbox"/> Easily Winded	<p><b>Yes No</b></p> <input type="checkbox"/> <input type="checkbox"/> Radiation/Chemo <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> Heart Disease/Trouble <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> <input type="checkbox"/> Hay Fever/Allergies <input type="checkbox"/> <input type="checkbox"/> Stroke <p><b>Women:</b></p> <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> <input type="checkbox"/> Breast-feeding? <input type="checkbox"/> <input type="checkbox"/> Birth Control Pills?	<p><b>Allergies:</b></p> <p><b>Yes No</b></p> <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> <input type="checkbox"/> Barbituates <input type="checkbox"/> <input type="checkbox"/> Penicillin <input type="checkbox"/> <input type="checkbox"/> Codeine <input type="checkbox"/> <input type="checkbox"/> Sulfa <input type="checkbox"/> <input type="checkbox"/> Iodine <input type="checkbox"/> <input type="checkbox"/> Latex <input type="checkbox"/> <input type="checkbox"/> Sedatives Please list any other allergies: _____ _____ _____
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Name of Medical Doctor: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
 Are you currently under medical treatment? \_\_\_\_\_ If yes, what? \_\_\_\_\_  
 Have you ever been hospitalized for any surgical operation or serious illness? \_\_\_\_\_ If yes, what? \_\_\_\_\_

List medications you are currently taking: \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_  
 Do you use tobacco? \_\_\_\_\_ Do you use alcohol? \_\_\_\_\_ Do you use cocaine or other drugs? \_\_\_\_\_

## Patient dental history

<p><b>Yes No</b></p> <input type="checkbox"/> <input type="checkbox"/> Do your gums bleed while brushing or flossing? <input type="checkbox"/> <input type="checkbox"/> Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> <input type="checkbox"/> Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> <input type="checkbox"/> Do you feel pain to any of your teeth? <input type="checkbox"/> <input type="checkbox"/> Have you had any head, neck or jaw injuries? <input type="checkbox"/> <input type="checkbox"/> Do you bite your lips or cheeks frequently? <input type="checkbox"/> <input type="checkbox"/> Have you ever had any difficult extractions? <input type="checkbox"/> <input type="checkbox"/> Have you ever had prolonged bleeding following extractions? <input type="checkbox"/> <input type="checkbox"/> Have you had orthodontic work (braces)?	<input type="checkbox"/> <input type="checkbox"/> Have you ever had instruction on the correct method of brushing and flossing your teeth? <input type="checkbox"/> <input type="checkbox"/> Have you ever had any instructions on the care of your gums? <input type="checkbox"/> <input type="checkbox"/> Have you ever been diagnosed with a gum disease or had any periodontal treatment?  <p><b>Have you ever experienced any of the following:</b></p> <input type="checkbox"/> <input type="checkbox"/> Problems in your jaw? <input type="checkbox"/> <input type="checkbox"/> Clicking? <input type="checkbox"/> <input type="checkbox"/> Pain (joint, ear, side of face?) <input type="checkbox"/> <input type="checkbox"/> Difficulty in opening or closing? <input type="checkbox"/> <input type="checkbox"/> Difficulty in chewing? <input type="checkbox"/> <input type="checkbox"/> Do you have frequent headaches? <input type="checkbox"/> <input type="checkbox"/> Do you clench or grind your teeth?
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## Signature

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

X \_\_\_\_\_ (Patient, Parent, or Guardian) Date: \_\_\_\_\_

Please print patient's name: \_\_\_\_\_ Patient's Birthdate: \_\_\_\_\_