

Patient Medical History - Personal and Confidential

Patient's Name _____ D.O.B. _____ Date _____

Physician _____ Office Phone _____ Date of Last Medical Exam _____

- | | Yes No | | Yes No |
|---|---|--|---|
| 1. Are you under medical treatment now? If yes explain _____ | <input type="checkbox"/> <input type="checkbox"/> | 8. Are you allergic to or have you had any reactions to the following? | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? If yes explain. _____ | <input type="checkbox"/> <input type="checkbox"/> | Local Anesthetics (eg. Novocaine)..... | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ | <input type="checkbox"/> <input type="checkbox"/> | Penicillin or other antibiotics..... | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Do you use tobacco? _____ | <input type="checkbox"/> <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Alcoholism? _____ | <input type="checkbox"/> <input type="checkbox"/> | Sedatives..... | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Drug abuse? _____ | <input type="checkbox"/> <input type="checkbox"/> | Iodine..... | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Women Only: | | Aspirin..... | <input type="checkbox"/> <input type="checkbox"/> |
| a) Are you pregnant or think you may be pregnant? _____ | <input type="checkbox"/> <input type="checkbox"/> | Latex..... | <input type="checkbox"/> <input type="checkbox"/> |
| b) Are you nursing? _____ | <input type="checkbox"/> <input type="checkbox"/> | Metals or jewelry..... | <input type="checkbox"/> <input type="checkbox"/> |
| c) Are you taking birth control pills? _____ | <input type="checkbox"/> <input type="checkbox"/> | Other..... | <input type="checkbox"/> <input type="checkbox"/> |
| 10. Do you HAVE or have you HAD any of the following? | | 9. Have you been warned against taking any medication..... | <input type="checkbox"/> <input type="checkbox"/> |
| | | If so list _____ | |

- | | Yes No | | Yes No | | Yes No |
|---|---|------------------------------------|---|---------------------------|---|
| High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> | Pace Maker | <input type="checkbox"/> <input type="checkbox"/> | Abnormal Bleeding | <input type="checkbox"/> <input type="checkbox"/> |
| Epilepsy/Convulsions | <input type="checkbox"/> <input type="checkbox"/> | Stroke | <input type="checkbox"/> <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> | Respiratory Problems..... | <input type="checkbox"/> <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> <input type="checkbox"/> | Fainting/Seizures..... | <input type="checkbox"/> <input type="checkbox"/> | Asthma | <input type="checkbox"/> <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> <input type="checkbox"/> | Anemia | <input type="checkbox"/> <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> <input type="checkbox"/> | Emphysema | <input type="checkbox"/> <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> <input type="checkbox"/> | Cancer or Tumor..... | <input type="checkbox"/> <input type="checkbox"/> | Tuberculosis (TB) | <input type="checkbox"/> <input type="checkbox"/> |
| Congenital Heart Defect | <input type="checkbox"/> <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> <input type="checkbox"/> | Arthritis | <input type="checkbox"/> <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> <input type="checkbox"/> |
| Artificial Heart Valve/
Open Heart Surgery | <input type="checkbox"/> <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> <input type="checkbox"/> | Kidney Diseases | <input type="checkbox"/> <input type="checkbox"/> |
| Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> | Hepatitis/Type..... | <input type="checkbox"/> <input type="checkbox"/> | Hard of Hearing..... | <input type="checkbox"/> <input type="checkbox"/> |
| Angina | <input type="checkbox"/> <input type="checkbox"/> | Jaundice | <input type="checkbox"/> <input type="checkbox"/> | Other..... | <input type="checkbox"/> <input type="checkbox"/> |
| | | Sexually Transmitted Disease | <input type="checkbox"/> <input type="checkbox"/> | | |

Patient Dental History

- | | Yes No | | Yes No |
|---|---|--|---|
| 1. Do you feel pain to any of your teeth? If so what? _____ | <input type="checkbox"/> <input type="checkbox"/> | 5. Do you have frequent headaches? | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> <input type="checkbox"/> | 6. Do you clench or grind your teeth? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> <input type="checkbox"/> | 7. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Have you ever experienced any of the following problems in your jaw? | | 8. Have you had any orthodontic or periodontal work? | <input type="checkbox"/> <input type="checkbox"/> |
| a) Clicking? | <input type="checkbox"/> <input type="checkbox"/> | 9. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)? | <input type="checkbox"/> <input type="checkbox"/> | | |
| c) Difficulty in opening or closing? | <input type="checkbox"/> <input type="checkbox"/> | | |
| d) Difficulty in chewing? | <input type="checkbox"/> <input type="checkbox"/> | | |

Thank you for filling out this form completely. x _____

Please take a moment to review your medical history and list any changes such as recent illnesses or surgeries, heart problems, new medications, etc.

Thank You.

HEALTH HISTORY UPDATE

Patient Name: _____

Date: _____

CURRENT MEDICATIONS

Health Changes _____ 1. _____

_____ 2. _____

_____ 3. _____

_____ 4. _____

Patient's Signature: _____ Staff Initials: _____

Date: _____

CURRENT MEDICATIONS

Health Changes _____ 1. _____

_____ 2. _____

_____ 3. _____

_____ 4. _____

Patient's Signature: _____ Staff Initials: _____

Date: _____

CURRENT MEDICATIONS

Health Changes _____ 1. _____

_____ 2. _____

_____ 3. _____

_____ 4. _____

Patient's Signature: _____ Staff Initials: _____

Date: _____

CURRENT MEDICATIONS

Health Changes _____ 1. _____

_____ 2. _____

_____ 3. _____

_____ 4. _____

Patient's Signature: _____ Staff Initials: _____