John L. Starks, DDS

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑

If yes, what medication(s) are you taking? _____

MEDICAL HEALTH HISTORY:
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems ❑
- Chest Pain ❑
- Shortness of breath ❑
- Blood pressure problem ❑
- Heart murmur ❑
- Heart valve problem ❑
- Taking heart medication ❑
- Rheumatic fever ❑
- Pacemaker ❑
- Artificial heart valve ❑

Blood Problems ❑
- Easy bruising ❑
- Frequent nose bleeds ❑
- Abnormal bleeding ❑
- Blood disease (anemia) ❑
- Ever require a blood transfusion? ❑

Allergy Problems ❑
- Hay fever ❑
- Sinus problems ❑
- Skin rashes ❑
- Taking allergy medication ❑
- Asthma ❑

Intestinal Problems ❑
- Ulcers ❑
- Weight gain or loss ❑
- Special diet ❑
- Constipation/Diarrhea ❑
- Kidney or bladder problems ❑

Bone or Joint Problems ❑
- Arthritis ❑
- Back or neck pain ❑

Joint replacement (e.g., total hip, pins, or implants) ❑
Fainting Spells, Seizures, or Epilepsy ❑
Frequent or severe headaches ❑
Thyroid problems ❑
Persistent cough or swollen gland ❑
Premedications required by physician ❑
Diabetes ❑
- Urinate more than 6 times a day ❑
- Thirsty or mouth is dry much of the time ❑
- Family history of diabetes ❑

Tuberculosis or other respiratory disease ❑
Cancer/Tumor ❑

Do you drink alcohol? ❑
Do you smoke? ❑
- If so, how much? _____

Hepatitis, jaundice, or liver trouble ❑
Herpes or other STD ❑
HIV-positive/AIDS ❑
Glaucoma ❑
Do you wear contact lenses? ❑
History of head injury ❑
Epilepsy or other neurological disease? ❑
History of alcohol or drug abuse? ❑
Do you have any disease, condition, or problem not listed previously that you feel we should know about? ❑
- If so, please describe _____

Are you allergic or have you reacted adversely to any of the following:

Local anesthetics ("Novocaine") ❑
Penicillin or other antibiotics ❑
Sulfa drugs ❑
Barbiturates, sedatives, or sleeping pills ❑
Aspirin, Acetaminophen, or Ibuprofen ❑
Codeine, Demerol or other narcotics ❑
Reaction to metals ❑
Latex or rubber dam ❑
Other ❑

During the past 12 months have you taken any of the following?

Antibiotics or sulfa drugs ❑
Anticoagulants (e.g., Coumadin) ❑
High blood pressure medicine ❑
Tranquilizers ❑
Insulin, Orinase, or similar drug ❑
Aspirin ❑
Digitalis or drugs for heart trouble ❑
Nitroglycerin ❑
Cortisone (steroids) ❑
Other ❑

Women

Are you taking contraceptives or other hormones? ❑
Are you pregnant? ❑
If so, expected delivery date: _____
Are you nursing? ❑

AUTHORIZATION & RELEASE:

I certify that all of the information above has been read and understood by me. I have answered all questions accurately and understand that incorrect information could adversely affect my health. I understand that my dental insurance is a benefit to me from my employer, and while the office is happy to assist me with billing for my dental services, I am ultimately responsible for payment of my account within 45 days regardless of insurance participation. I agree to these stipulations on my own behalf and any dependants who receive treatment in this office. **I also acknowledge receipt of the HIPPA Notice of Privacy Practices: I Assign Insurance Benefits to the Provider:**

Signed _____ Date _____
Parent (if patient is a minor)

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DENTAL HEALTH HISTORY

Please mark any question that you would answer "YES":

Are you apprehensive about dental treatment? _____ ❑
Have you had problems with previous dental treatment? _____ ❑
Do you gag easily? _____ ❑
Do you wear dentures? _____ ❑
Does food catch between your teeth? _____ ❑
Do you have difficulty in chewing your food? _____ ❑
Do you chew on only one side of your mouth? _____ ❑
Do you avoid brushing any part of your mouth because of pain? _____ ❑
Do your gums bleed easily? _____ ❑
Do your gums bleed when you floss? _____ ❑
Do your gums feel swollen or tender? _____ ❑
Have you ever noticed slow healing sores in or about your mouth? _____ ❑
Are your teeth sensitive? _____ ❑
Do you feel twinges of pain when your teeth come in contact with:
Hot foods or liquids? _____ ❑
Cold foods or liquids? _____ ❑
Sours? _____ ❑
Sweets? _____ ❑
Do you take fluoride supplements? _____ ❑
Are you dissatisfied with the appearance of your teeth? _____ ❑
Do you prefer to save your teeth? _____ ❑
Do you want complete dental care? _____ ❑
How often do you brush? _____ How often do you floss? _____
Does your jaw make noise so that it bothers you or others? _____ ❑
Do you clench or grind your jaws frequently? _____ ❑
Do your jaws ever feel tired? _____ ❑
Does your jaw get stuck so that you can't open freely? _____ ❑
Does it hurt when you chew or open wide to take a bite? _____ ❑
Do you have earaches or pain in front of the ears? _____ ❑
Do you have any jaw symptoms or headaches upon awaking in the morning? _____ ❑
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____ ❑
Do you find jaw pain or discomfort extremely frustrating or depressing? _____ ❑
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____ ❑
Do you have a temporomandibular disorder (TMD, TMJ)? _____ ❑
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____ ❑
Are you unable to open your mouth as far as you want? _____ ❑
Are you aware of an uncomfortable bite? _____ ❑
Have you had a blow to the jaw (trauma)? _____ ❑
Are you a habitual gum-chewer or pipe smoker? _____ ❑
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____ ❑
If so, please describe: _____

_____

(Please fill out other side completely)