# MEDICAL HISTORY

NAME: _____ Date of Birth: _____

*Your answers are for our records only and will be considered confidential.*

1. Has there been any change in your general health within the past year? Yes No
2. Are you now under the care of a physician? Yes No
   a. If so, what is the condition being treated? _____
   _____
3. The name of physician _____
4. Have you been hospitalized or had a serious illness within the past 5 years? Yes No
5. Do you have, or have you had, any of the following diseases or problems?
   - Rheumatic fever or rheumatic heart disease Yes No
   - Mitral Valve Prolapse Yes No
   - Heart Murmur Yes No
   - Congenital heart lesions Yes No
   - Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, pacemaker, artificial heart valves) Yes No
   - Cancer (chemotherapy, radiation) Yes No
   - Allergy Yes No
   - Sinus trouble Yes No
   - Asthma or hay fever Yes No
   - Fainting spells, dizziness, Epilepsy, or seizures Yes No
   - Diabetes Yes No
   - Hepatitis, jaundice, or liver disease Yes No
   - Arthritis Yes No
   - Inflammatory rheumatism (painful, swollen joints) Yes No
   - Osteoporosis Yes No
   - Artificial joints Yes No
   - Kidney trouble Yes No
   - Respiratory Problems, Emphysema Yes No
   - Tuberculosis Yes No
   - Persistent cough or cough up blood Yes No
   - Low blood pressure Yes No
   - Sexually Transmitted Disease Yes No
   - AIDS or HIV Yes No
   - Are you at high risk of HIV? Yes No
   - Abnormal bleeding Yes No
   - Bruise easily Yes No
   - Blood transfusion Yes No
   - Blood Disease Yes No
   - Anemia Yes No
   - Mental or physical disability Yes No
   - Glaucoma Yes No
   - Ulcers Yes No
6. Have you ever used Phen-Fen or other diet suppression combination for weight loss? Yes No
   a. If so, have you been evaluated by your physician or cardiologist or have you undergone an EKG? Yes No
7. Have you had surgery or x-ray treatment for tumor, growth, or other condition of your head or neck? Yes No
8. Are you taking any drugs or medications? Yes No
   a. If so, what? _____
   _____
   _____
9. Are you taking any of the following?:
   a. Antibiotics Yes No
   b. Anticoagulants (blood thinners) Yes No
   c. Medicine for high blood pressure Yes No
   d. Cortisone (steroids) Yes No
   e. Tranquilizers Yes No
   f. Antihistamines Yes No
   g. Aspirin Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug Yes No
   i. Digitalis or drugs for heart trouble Yes No
   j. Nitroglycerin Yes No
   k. Oral contraceptive or other hormonal therapy Yes No
   l. Other _____
10. Are you allergic or have you reacted adversely to any of the above? Yes No
    a. Any other? _____
11. Do you use tobacco products? Yes No
12. Have you had any serious trouble associated with any previous dental treatment? Yes No
13. Do you have any disease, condition, or problem not listed above? Yes No
14. Do you have any allergies to metal or jewelry? Yes No

WOMEN

15. Are you pregnant? Yes No

DENTAL HISTYORY & TMJ

1. Do you have pain from heat, cold, or sweets? Yes No
2. Have you lost any of your teeth? Yes No

a. If so, how long have they been missing?

3. Do your gums bleed when brushing or flossing? Yes No
4. Do you have pain from biting or chewing? Yes No
5. Experience ringing in your ears? Yes No
6. Do you clench your teeth? Yes No
7. Do you have difficulty opening or closing your mouth? Yes No
8. Do you have headaches? Yes No
9. Do you have clicking or popping by your ears when you open or close your mouth? Yes No
10. Do you have eye or facial swelling? Yes No
11. Do you have neck problem? Yes No
12. Do you have back problems? Yes No
13. Are you satisfied with the appearance of your teeth? Yes No

What did you like about your last dental office? _____
_____

What did you dislike about your last dental office? _____
_____

**CHIEF DENTAL COMPLAINT**: _____
_____
_____

_____ _____
***Signature of Patient*** ***Date***

_____ _____
***Signature of Doctor*** ***Date***