MEDICAL HEALTH HISTORY

PATIENT NAME: _____ Birthdate: _____Preferred to be called_____

CIRCLE YOUR ANSWERS

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain:

_____

3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain:

_____

---

4. Yes No Are you being treated by a physician now? For what? _____

Name of your physician: _____ Date of last Medical Exam: _____
Name of your Former Dentist: _____ How long since you were last seen? _____

Yes No Frequent headaches
Yes No Heart disease or Heart attack
Yes No Heart murmur or Heart defects or Pacemaker
Yes No Rheumatic Fever
Yes No Stroke
Yes No High Blood Pressure
Yes No TB, Emphysema, or other lung disease
Yes No Hepatitis A, B, C
Yes No Stomach problems or Ulcers
Yes No Diabetes
Yes No Mitral Valve Prolapse
Yes No Seizures
Yes No Dry Mouth

Yes No Thyroid, Adrenal Disease
Yes No Steroid Therapy
Yes No Herpes
Yes No Kidney or Bladder Disease
Yes No Alcohol/Tobacco in any form
Yes No Phen fen diet pills or any other diet pills
Yes No Bisphosphonate Therapy (Bone Loss)
Yes No Sleep Apnea or chronic snoring
Yes No HIV positive or AIDS
Yes No Tumors/Cancer Radiation/Chemo Y N
Yes No Currently pregnant or nursing
Yes No Currently taking birth control pills
Yes No Artificial Joint

Current Medications:

_____

Is keeping your teeth important to you? Y N If yes, why? _____
On a scale of 1-10, 10 being the best, where would you rate your smile? _____
On a scale of 1-10, 10 being the best, how do you rate your oral health? _____

Have you experienced any of the following:

Yes No Bleeding gums
Yes No Bad breath or sour taste in mouth
Yes No Soreness in jaw
Yes No Is it hard for you to open wide
Yes No Clicking or popping in jaw

Yes No Food catching between teeth
Yes No Clenching or grinding teeth
Yes No Have you ever been injured in your mouth or head
Yes No Sensitivity to hot or cold

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

Aspirin ____
Erythromycin ____
Sulfa Drugs ____
Barbiturates ____

Codeine ____
Penicillin ____
Latex ____
Ibuprofen _____

Local Anesthetic
Tetracycline ____
Acetaminophen ____
Other____

Please list any other allergies or concerns: _____

Patient or Guardian Signature:_____Date:_____

Reviewed:_____ Reviewed:_____ Reviewed:_____ Reviewed:_____