PATIENT'S MEDICAL HISTORY

Please answer EACH question.

1. Are you in good health? ☐ Yes ☐ No
2. Date of last physical examination _____
3. Have you ever been hospitalized? ☐ Yes ☐ No
4. **Are you sensitive or allergic to any drugs? ☐ Yes ☐ No**
   Which kind(s)

6. Do you wear a cardiac pacemaker? ☐ Yes ☐ No
7. Have you had heart surgery? ☐ Yes ☐ No
8. Are you now under care of an M.D.? ☐ Yes ☐ No
9. Have you had any serious illness? ☐ Yes ☐ No
10. Blood pressure, if known _____

5. **Are you taking any drugs or medication? ☐ Yes ☐ No**
   If so, what?

11. Do you have, or have you had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Heart Ailments	☐	☐	Fainting spells or seizures
☐	☐	Blood Diseases	☐	☐	Heart Murmur, Mitral Valve Prolapse	☐	☐	Sinus Trouble
☐	☐	Hepatitis, jaundice, or liver disease	☐	☐	High Blood Pressure	☐	☐	Rheumatism or Arthritis
☐	☐	Respiratory Disease	☐	☐	Kidney Disease	☐	☐	Head Injuries
☐	☐	Tuberculosis	☐	☐	Tumors or Growths	☐	☐	Stomach Ulcers
☐	☐	Nervous Disorders	☐	☐	Radiation treatment of any kind	☐	☐	Venereal Diseases
☐	☐	Diabetes	☐	☐	Allergies	☐	☐	Epilepsy
☐	☐	Excessive Bleeding	☐	☐	Asthma or Hay Fever	☐	☐	Stroke
☐	☐	Blood transfusion	☐	☐	Artificial Joints, Implants	☐	☐	HIV/AIDS
☐	☐	Use tobacco products	☐	☐	Osteoporosis Medications	☐	☐	Latex Allergy

Pregnant Y N Months _____ OBGYN _____ Phone _____

Physician's name _____
Address _____ Phone _____

DENTAL HISTORY

1. How long since you've been to a dentist? _____
2. Have you ever been treated for periodontal disease? ☐ Yes ☐ No
3. Have you ever had any complications from an extraction? ☐ Yes ☐ No
4. Have you ever had a popping or clicking near your ear when you chew? ☐ Yes ☐ No
5. Do you grind your teeth? ☐ Yes ☐ No
6. Do your gums bleed when you brush? ☐ Yes ☐ No
7. Do you have sores, blisters or swelling on your gums, lips or cheeks? ☐ Yes ☐ No
8. Have you ever had orthodontic treatment? ☐ Yes ☐ No
9. When was your last set of full mouth X-rays taken?
   Date: _____ Where? _____

CONSENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit.

Signature _____ Date _____

Relationship to Patient _____

HEALTH HISTORY UPDATE

Date _____ Date _____
Changes _____ Changes _____
Signature _____ Signature _____

Date _____ Date _____
Changes _____ Changes _____
Signature _____ Signature _____

Date _____ Date _____
Changes _____ Changes _____
Signature _____ Signature _____