**PATIENT MEDICAL HISTORY**

Name & Phone Number of Family Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under any medical treatment now **Y N**

Have you ever had any surgical operations **Y N** List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medication now **Y N** List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Do you take any medication for Osteoporosis , like Fosamax, or Boniva? *Y N***

**\*Have you ever had any Radiation Therapy to your Head, Face or Neck? *Y N***

**\*Are you allergic to or have you had any reaction to the following?**

Latex **Y N** Sulfa Drugs **Y N** Local Anesthetics **Y N**

Aspirin **Y N** Sedatives **Y N** Penicillin or other antibiotics **Y N**

**\*Do you have or have you had any of the following?**

High/Low Blood Pressure Y N Stroke Y N Joint Replacement Y N

Heart Attack Y N Thyroid Problem Y N Arthritis Y N

Cardiac Pacemaker Y N Diabetes Y N Hepatitis/Jaundice Y N

Chest Pains Y N Asthma Y N Hay Fever/Allergies Y N

Heart Murmur Y N Rheumatic Fever Y N Mitral Valve Prolapse Y N Emphysema Y N Stomach Trouble Y N Fainting/Seizures Y N Glaucoma Y N Liver Disease Y N Cancer Y N Kidney Diseases Y N Radiation Therapy Y N Respiratory Problems Y N

***(Women Only)***

\***Are you pregnant or think you may be *Y N*** Taking birth control pills ***Y N***

**Patient Dental History**

Date of last dental visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit \_\_\_Exam/Check-up \_\_\_Emergency \_\_\_Consultation

Do you smoke or use smokeless tobacco **Y N**

Please check any of the following that apply:

\_\_Discomfort, clicking or popping jaw \_\_Teeth Grinding

\_\_Red, Swollen or bleeding gums \_\_Broken/Chipped Teeth

\_\_Sensitive tooth, teeth or gums \_\_Stained Teeth

\_\_Blisters/Sores in or around mouth \_\_Bad Breath

\_\_Lost/Broken fillings \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

**Responsible Party for Patient:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please Print)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_