

PATIENT MEDICAL HISTORY

Please print

legibly

Mr./Mrs./Miss./ MS./Dr./Fr/Sr.	First Name	Last Name	M.I.
Home Phone ()	Cell Phone ()	Date of Birth	
Work Phone ()	Fax ()	Gender	
Home Address		City/State/Zip	
Employer Name		Occupation	
Employer Address		Social Security Number	
Referring Doctor		Family Dentist	
Family Physician		Family Physician Phone ()	
Guarantor		Date of Last Physical Exam / /	
Home E-mail		Work E-mail	
Insurance Company		Address	
Subscriber's Name		Subscriber's Social Security Number	
Subscriber's DOB		Group #	Relationship

Yes	No	Don't Know
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1. Have you ever had any ALLERGIC or ADV ERSE reactions to LATEX gloves, LATEX adhesive (ex: band aids) if so explain below?			
2. Have you ever had any ALLERGIC or ADVERSE reactions Medications such as antibiotics, local anesthetics, Advil, etc.?			
3. Do you have or you had any CARDIOVASCULAR issues such as Heart Attack, Stroke, Chest pain, Angina, Irregular heartbeat, Heart Surgery, Infective Endocarditis, Heart Murmur or other? If yes, please explain:			
4. Have you been advised to take prophylactic antibiotics prior to dental visit? If so please explain:			
5. Have you ever had any serious trouble associated with previous dental treatment? (Claustrophobia, anxiety, panic attacks) if yes, please explain:			
6. Have there been any changes in your general health within the past year? If yes, please explain:			
7. Have you ever had Chemotherapy, Radiation, Surgery or other treatment for CANCER? If yes, please explain:			
8. Do you have or have had any TEMPO-MANDIBULAR JOINT (TMJ) problems, Bruxism? If yes, please explain:			
9. Do you have or have you ever had High Blood Pressure? Please explain :			
10. Do you have or have you ever had any of the following INFECTIOUS DISEASE such as Hepatitis, Tuberculosis, HIV/AIDS or any other? Please explain:			
11. Do you have or have you ever had any ENDOCRAINE conditions such as Diabetes, Insulin or Non-Insulin dependent, Thyroid disorder, Adrenal disorder or any other conditions?			
12. Do you have or have you ever had any RESPIRATORY conditions such as Asthma, COPD/Emphysema, Tuberculosis, Sinus Infection or other?			
13. Do you have or have you ever had any LIVER conditions such as Hepatitis, Cirrhosis or other liver conditions?			

14. Do you have or have you ever had any NEUROLOGIC conditions such as Seizures, Epilepsy, Stroke, Fainting, Migraines, Neuropathy/Neuralgia or other neurologic conditions?			
15. Do you have or have you ever had any ORTHOPEDIC conditions such as Arthritis, Neck or Spinal injuries, Prosthetic joints (hip, knee, etc.) or any other?			
16. Are you taking or have you ever taken bisphosphonates? (Fosamax, Actonel, Zometa)			
17. Have ever received PSYCHIATRIC treatment?			
18. Do you have or have you ever had any GASTRO-INTESTINAL conditions such as Stomach Ulcers, Colitis, Acid Reflux or other?			
19. Preferred Pharmacy Name/address/Phone number:			
20. Do you have any disease, condition or problem not listed above? Specify.			
21. 19. Are you taking any medication or drugs? If yes, please list them below.			

Women only:

Taking birth control pills:	YES / NO	I am or may be pregnant:	YES/NO
I am pregnant:	YES / NO	I am nursing :	YES/NO

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of control.

Expecting Mothers:

Please list due date, name of Obstetrician and contact information:

Patient Signature (Parent signature if patient is under 18 years of age).
