

Name _____

Date _____

Medical Information

Are you having pain or discomfort at this time?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a patient in the hospital during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been under the care of a medical doctor or been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Physician's Name _____	Phone _____	
Address _____		
Have you had any previous surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
Procedures & dates _____		
Have you taken any medication or drugs during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
Are you now taking any medication or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____		
Are you sensitive or allergic to any medication or anesthetics?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____		
Have you or any family members had any problems with anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>

FOR WOMEN ONLY

Yes No	Yes No	Yes No
Is there any possibility of pregnancy? <input type="checkbox"/> <input type="checkbox"/>	What month? _____	Are you nursing? <input type="checkbox"/> <input type="checkbox"/>
		Are you taking birth control pills? <input type="checkbox"/> <input type="checkbox"/>

Indicate which of the following you have had or have at the present:

	Yes	No		Yes	No		Yes	No
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>				Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectorus	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints (hip, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (serum)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Sub-bacterial Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Phen-Fen	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Transplants	<input type="checkbox"/>	<input type="checkbox"/>

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?

Do your ankles swell during the day?

Have you gained or lost more than 10 pounds in the past year?

Are you on a special diet?

Are you taking Herbal Supplements?

Are you taking Bisphosphonates?

Do you have or have you had any diseases, condition, or problem not listed?

Current body weight _____

Do you smoke? If yes, how many packs per day? _____

Dental History

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/food?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores/lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced the following: (circle please)			Have you ever had instructions on the correct care of teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking		Difficulty in opening/closing			
Pain (ear, side of face, joint)		Difficulty in chewing			

Patient Signature: _____

Doctor comment: _____ Doctor Signature _____