MEDICAL HISTORY

Name(s) of Medical Doctor(s) _____

Address(es) _____

Telephone Number(s) _____

Date of last exam(s) _____ Are you in good health _____

Please describe any current medical treatment or impending hospitalization _____

_____

Please list any medications or nutritional supplements you are currently taking along with dosage and frequency

_____ _____

_____ _____

_____ _____

Past hospitalizations or surgery _____Any Complications_____

Do you now have, or have you had any of the following:

yes	no	heart disease	yes	no	asthma	yes	no	artificial joints or heart valves
yes	no	heart murmur or defect	yes	no	respiratory disease	yes	no	transplanted organs
yes	no	high blood pressure	yes	no	diabetes	yes	no	physical disabilities
yes	no	disease of the blood	yes	no	malignancy	yes	no	aids or other immuno suppressive
yes	no	excessive bleeding	yes	no	measles	yes	no	psychiatric/emotional problems
yes	no	allergies to anesthetics	yes	no	rheumatic fever	yes	no	fainting spells/seizures - epilepsy
yes	no	allergies to medicines	yes	no	stroke	yes	no	cardiac pacemaker
		_____	yes	no	tuberculosis			
yes	no	other allergies	yes	no	ulcer			
		_____	yes	no	frequent headaches			
yes	no	kidney disease	yes	no	sinus condition			
yes	no	thyroid problems	yes	no	other _____			
yes	no	venereal disease	yes	no	are you pregnant			
yes	no	scarlet fever	yes	no	have you ever taken fluoride supplements			
yes	no	burning sensation on tongue or lip						

I authorize the release of records from my current medical physician(s) and previous dentist. _____yes

Your Signature _____ Today's Date _____

TO BE FILLED OUT BY CLINICAL STAFF

Previous dentist_____Last Oral Exam_____

Last complete series of x-rays_____Extractions_____Reason_____

Replacement of missing teeth_____

Sensitivity - Hot - Cold - Pressure_____

Periodontal Treatment_____Orthodontic Treatment_____Endodontic Treatment_____

Gingival bleeding when brushing_____flossing_____

Gingival swelling_____Mobility_____

TMJ Evaluation - Headaches_____Pain in and around ears_____

Sinus pain_____Other head or neck pain_____

Popping or clicking or pain on opening_____

Previous treatment or occlusal adjustment_____

completed by _____ *date* _____