Name:_____ **Date of Birth:**_____

PATIENT MEDICAL HISTORY: *CIRCLE*

1. Have you been under the care of a physician during the last two years? **YES NO**
   If Yes, please describe condition:_____
   Physicians name_____ Phone_____
2. Have you taken any medications/prescriptions during the past two years? **YES NO**
   If Yes, please list:_____
   _____
3. Do you have any known allergies? **YES NO**
   If Yes, please list:_____
4. Have you been hospitalized or had any surgery in the past 5 years? **YES NO**
   If Yes, please describe:_____
5. If female, are you now pregnant? Due date?_____ **YES NO**
   Are you currently nursing? **YES NO**
6. ***If you have had any of the following conditions, circle "Yes" & indicate Month/Year, if not circle "No".***

Yes No AIDS/HIV	**Yes No** Diabetes	**Yes No** Hyper/Hypo Thyroidism
Yes No Alcohol Addiction	**Yes No** Dizzy/Fainting Spells	**Yes No** Jaundice/Liver Disease
Yes No Allergies - Seasonal	**Yes No** Drug Addiction	**Yes No** Kidney Trouble
Yes No Anemia	**Yes No** Dry Mouth	**Yes No** Mental/ Nervous Disorder
Yes No Anorexia/Bulimia	**Yes No** Emphysema/Bronchitis	**Yes No** Mitral Valve Prolapse____/____
Yes No Arthritis – OA or RA	**Yes No** Epilepsy/Seizures____/____	**Yes No** Osteoporosis/Bone Disease
Yes No Artificial Heart Valves____/____	**Yes No** Fibromyalgia	**Yes No** Prolonged Bleeding
Yes No Artificial Joints____/____	**Yes No** Heart Attack____/____	**Yes No** Psychiatric Treatment
Yes No Asthma	**Yes No** Heart Disease	**Yes No** Radiation Treatment____/____
Yes No Cancer/Tumors	**Yes No** Heart Murmur	**Yes No** Rheumatic Fever
Yes No Chemotherapy____/____	**Yes No** Heart Pacemaker	**Yes No** Sinus Trouble
Yes No Chest Pains	**Yes No** Heart Surgery____/____	**Yes No** Stroke____/____
Yes No Cold Sores	**Yes No** Herpes	**Yes No** Tuberculosis____/____
Yes No Congenital Heart Lesions	**Yes No** Hepatitis____/____	**Yes No** Ulcers
Yes No Dementia/Alzheimer's Disease	**Yes No** High Blood Pressure	**Yes No** Venereal Disease
Yes No Developmental Disabilities		**Yes No** Other_____

Do You Use Tobacco? ☐ Yes ☐ No

☐ Cigarettes – Packs/Day:_____ ☐ Chew - #/Day:_____ ☐ Pipe - #/Day:_____ ☐ Cigars - #/Day:_____

PATIENT DENTAL HISTORY

1. How long has it been since your last dental visit?_____
2. Are you having any specific problems with your teeth, gums or mouth at this time? **YES NO**
   If Yes please list_____
3. Do you clench or grind your teeth? If Yes, When? Day or Night **YES NO**
4. Do you notice any popping, clicking or soreness in the jaw? **YES NO**
5. Have you undergone any previous periodontal surgery or oral surgery? **YES NO**
   If Yes, please list_____
6. Have you had any head, neck or jaw injuries? **YES NO**
7. Have you had any serious trouble associated with any previous dental treatment? **YES NO**
   If Yes, please list_____
8. Have you ever experienced any ill effects from dental anesthetics, antibiotics or any other drug? **YES NO**
   If Yes, please list_____

Signature:_____ Relationship to Patient:_____ Date:_____

Doctor's Signature:_____ Date:_____ B/P:_____ Pulse:_____