Medical and Dental History

Last Name: _____ First Name: _____ I Go By: _____

Home Address: _____ City/State: _____ Zip: _____

Phone: _____ E-mail Address: _____ Fax: _____

Employer: _____ Occupation: _____ Phone: _____ Ext: _____

Single: ___ Married: ___ Separated: ___ Divorced: ___ Widowed: ___ Spouse's Name: _____

SS#: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Name of your physician: _____ Name of your dentist: _____

Referred by: _____ Reason for appointment: _____

Name, address & phone # of nearest relative (not living with you): _____

_____

Circle the appropriate answer that applies to you. If in doubt, circle "DNK" for Do Not Know. Please fill in any other information in the provided blank spaces.

Dental History

1.	How would you describe your dental health?	Excellent	Good		Fair	Poor
2.	Have you ever had orthodontic treatment (brace)?			Yes	No	DNK
3.	Are your teeth sensitive to hot or cold?			Yes	No	DNK
4.	When were your teeth cleaned last? _____					
5.	If known, date of last full mouth dental X-rays: _____					
6.	Have you had previous gum trouble?			Yes	No	DNK
7.	Do you use mints, Lifesavers, hard candies, etc… regularly?			Yes	No	DNK

Problems relating to occlusion "bite" or jaw joint

1.	Are you aware of a tired feeling in your face?	Yes	No	DNK
2.	Do you have ringing or pain in your ears?	Yes	No	DNK
3.	Do you clench or grind your teeth?	Yes	No	DNK
4.	Do you have frequent headaches?	Yes	No	DNK
5.	Do you have pain around your ears, eyes, head or neck?	Yes	No	DNK

General Health

1.	Do you have any type of health problem?	Yes	No	DNK
2.	Do you have any type of heart problems?	Yes	No	DNK
3.	Do you have high blood pressure?	Yes	No	DNK
4.	Do you have low blood pressure?	Yes	No	DNK

5.	Do you have shortness of breath after climbing a flight of stairs?	Yes	No	DNK
6.	Do you bleed for more than 30 seconds for a minor cut?	Yes	No	DNK
7.	Are you taking any medication? If so, please list: _____			
	_____			
8.	Have you been hospitalized in the last five years?	Yes	No	DNK
	If so, please explain: _____			
9.	Do you faint easily?	Yes	No	DNK
10.	Have you taken cortisone or steroids in the last six months?	Yes	No	DNK
11.	Have you been under the care of a physician in the last year, other than a routine physical?	Yes	No	DNK
12.	Have you had a major illness or serious operation in the last five years?	Yes	No	DNK
	If yes, please explain: _____			
13.	Have you had rheumatic fever?	Yes	No	DNK
14.	Do you have any type of artificial joint, heart valve or pacemaker now in place?	Yes	No	DNK
15.	Are you allergic to any medications?	Yes	No	DNK
	Please list: _____			

16. Please estimate the number of cups, glasses, etc. you consume each day on average:
    Coffee _____ Tea _____ Soft Drinks _____ Alcoholic Beverages _____

Family History

1.	Have any members of your family (blood kin) had heart disease, high blood pressure or diabetes? (please circle)	Yes	No	DNK
2.	Do any members of your family snore or have sleep apnea?	Yes	No	DNK

Medical History

1.	Anemia?	Yes	No	DNK
2.	Frequently swollen ankles?	Yes	No	DNK
3.	Stomach ulcers?	Yes	No	DNK
4.	Excessive thirst or hunger over an extended period of time?	Yes	No	DNK
5.	Change in urination frequency?	Yes	No	DNK
6.	Cuts tend to heal slowly?	Yes	No	DNK
7.	Diabetes?	Yes	No	DNK
8.	Thyroid disturbance or taken thyroid tablets?	Yes	No	DNK
9.	Tuberculosis or emphysema?	Yes	No	DNK

10.	Hepatitis?	Yes	No	DNK
11.	AIDS or AIDS-related complex or positive for the AIDS virus?	Yes	No	DNK
12.	Kidney or bladder disease problems?	Yes	No	DNK
13.	Arthritis or rheumatism?	Yes	No	DNK
14.	Venereal disease (syphilis, gonorrhea, herpes II)?	Yes	No	DNK
15.	Epilepsy, convulsions, or seizures?	Yes	No	DNK
16.	Cancer or radiation therapy?	Yes	No	DNK
17.	Mitral Valve Prolapse?	Yes	No	DNK
18.	Smoke or use tobacco in any form?	Yes	No	DNK
19.	Are you taking any anti-depressants or sleep medications?			
	If yes, please list: _____	Yes	No	DNK
20.	Are you taking any anticoagulants (blood thinners)?	Yes	No	DNK
21.	Are you taking antacids regularly?	Yes	No	DNK
22.	Glaucoma?	Yes	No	DNK
23.	Asthma, hay fever, or eczema?	Yes	No	DNK
24.	Liver problems?	Yes	No	DNK
25.	Males only: Prostrate problems?	Yes	No	DNK
26.	Females only: Are you pregnant?	Yes	No	DNK
	Are you taking birth control pills or other hormones?	Yes	No	DNK
27.	Esophageal Reflux (GERD)?	Yes	No	DNK

Do you have any disease, condition, or problem not listed above that you think we should know or that you believe would affect treatment in any way? _____

_____

_____

Patient's Signature: _____ Date: _____