

Patient Name _____

It is important that we know about your medical history. Many things have a direct bearing on your health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

Physician's Name _____ Date of Last Physical Examination _____

In Case of Emergency, Notify _____ Phone # _____

Nearest Relative _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Do you have any of the following? Please indicate with a check mark. ✓

Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	M.S./M.D./Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion Dates _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to _____	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (circle: A B C D E)	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Positive HIV (AIDS)			
<input type="checkbox"/>	<input type="checkbox"/>	Nervous System/Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	AIDS			

Explanation of Above: _____

Medications: List medications you are taking (or within past 30 days) (Prescribed or over-the counter, i.e. Antibiotics, Birth Control, Aspirin, etc) _____

Are you now, or have you ever taken a class of drugs called Bisphosphonates (i.e. Fosamax, Boniva, Skelid, etc.)?

Yes No Explain: _____

Have you had any clicking or discomfort in your jaw joints? Yes No Explain: _____

Are you currently under the care of a physician? Yes No Explain: _____

Have you been hospitalized for any reason in the past 5 years? Yes No Explain: _____

When was the last time you were at the dentist? _____ When was the last time you had a cleaning? _____

Why did you leave your last dentist? _____ How long have you had dental insurance? _____

Have you had any problems with previous dental treatment?

Yes No Explain: _____

Signature: _____

Dentist Notes

History Updates

Dates _____ By _____ Notes _____