



## 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

- |  |           |      |        |      |
|--|-----------|------|--------|------|
|  | Excellent | Good | Fair   | Poor |
| 1. How would you describe your dental health?                    |           |      |        |      |
| 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

- |   |     |    |     |
|---|-----|----|-----|
|   | Yes | No | DNK |
| 1. Are you aware of a tired feeling in your face?         |     |    |     |
| 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

- |  |     |    |     |
|--|-----|----|-----|
|  | Yes | No | DNK |
| 1. Do you have any type of health problem? |     |    |     |
| 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: _____<br>_____  |     |    |     |
| 8.  | Have you been hospitalized in the last five years?<br>If so, please explain: _____   | Yes | No | DNK |
| 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,<br>other than a routine physical?  | Yes | No | DNK |
| 12. | Have you had a major illness or serious operation in the last five years?<br>If yes, please explain: _____   | Yes | No | DNK |
| 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?<br>Please list: _____   | Yes | No | DNK |
| 16. | Please estimate the number of cups, glasses, etc. you consume each day on average:<br>Coffee _____ Tea _____ Soft Drinks _____ Alcoholic Beverages _____ |     |    |     |

### Family History

- |    |  |     |    |     |
|----|--|-----|----|-----|
| 1. | Have any members of your family (blood kin) had heart disease,<br>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: \_\_\_\_\_