Patient Medical History:

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To our patients: please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.
Please use an "X" to mark your answers to the following questions.

Yes	No	**Heart Health**
☐	☐	Angina or Chest Pain
☐	☐	Arteriosclerosis
☐	☐	Artificial heart valve
☐	☐	Congenital heart disease
☐	☐	Heart Attack
☐	☐	Heart disease/trouble
☐	☐	Heart Murmur
☐	☐	Pacemaker
☐	☐	Stroke
		Breathing Health:
☐	☐	Asthma or COPD
☐	☐	Emphysema
☐	☐	Sinus Trouble
☐	☐	Tuberculosis
☐	☐	Hay fever or Allergies
☐	☐	Easily Winded

Yes	No	**Cancer: _____**
		Date of Diagnosis:
☐	☐	Chemotherapy or Radiation
		Blood Health:
☐	☐	High or Low Blood Pressure
☐	☐	Anemia
☐	☐	Blood Transfusion
☐	☐	Hemophilia
		Neurological/Mental Health
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Epilepsy or Seizures
☐	☐	Brain injury or Concussion
☐	☐	Fainting
☐	☐	Post-Traumatic stress disorder
☐	☐	Mental health disorder
☐	☐	Neurological disorder

Yes	No	**Others:**
☐	☐	AIDS or HIV infection
☐	☐	Arthritis or Rheumatism
☐	☐	Chronic pain
☐	☐	Diabetes (Type I or II)
☐	☐	Eating disorder
☐	☐	Frequent infections
☐	☐	Gastrointestinal disease
☐	☐	Glaucoma
☐	☐	Hearing loss
☐	☐	Hepatitis or Liver disease
☐	☐	Headaches or Migraines
☐	☐	Joint replacement
☐	☐	Kidney problems
☐	☐	Osteoporosis
☐	☐	Sleep related disorders
☐	☐	Thyroid problems

Yes	No	**Allergies:**
☐	☐	Aspirin
☐	☐	Barbiturates, sedatives
☐	☐	Codeine
☐	☐	Iodine
☐	☐	Latex
☐	☐	Local Anesthetics
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sulfa drugs
☐	☐	Other Narcotics
☐	☐	Other Antibiotics
☐	☐	Other, please list:

_____
_____
_____
_____

**Do you have any disease or condition that is not listed? If so, please explain:_____

Medical Doctor's Name: _____ Date of last physical exam: _____

Preferred Pharmacy and Location: _____

Are you currently under medical treatment? _____ If yes, explain: _____

_____

In the past 5 years, have you been hospitalized, had a serious illness, or had an operation? _____

If yes, explain: _____

Medications and other Products/Substances:

Yes	No	
☐	☐	Do you use any form of **nicotine,** cigarettes, cigars, snuff, chew, vape?
☐	☐	Drink **alcoholic** beverages?
☐	☐	Controlled substances (drugs) including marijuana for medical or recreational uses. Substance:
☐	☐	Do you take any **prescriptions and/or over-the-counter medicines**? If yes, please list:

Yes	No	**Women Only**: Are you:
☐	☐	Taking Birth Control Pills?
☐	☐	Pregnant? if yes, number of weeks _____
☐	☐	Nursing?

Patient Dental History:

Yes	No		Yes	No		Yes	No	
☐	☐	Does the dentist make you nervous?	☐	☐	Do you have pain in your ear, joint or side of face?	☐	☐	Is it hard to open or close your mouth?
☐	☐	Are you happy with your smile?	☐	☐	Have you ever been diagnosed with gum disease?	☐	☐	Does your jaw click, pop, or hurt?
☐	☐	Have you had orthodontic work (braces)?	☐	☐	Are your teeth sensitive to hot, cold, sweet or sour?	☐	☐	Do you clench or grind your teeth?
☐	☐	Have you ever had any difficult extractions?	☐	☐	Have you had any head, neck, or jaw injuries?	☐	☐	Does is hurt to chew, bite, or swallow?
☐	☐	Do your gums bleed when you brush or floss?	☐	☐	Has a physician or previous dentist recommended **antibiotics** before dental work?			

**I certify that I have read and I understand the above information. I have answered the above questions completely, accurately, and to the best of my ability. I understand that providing incorrect information can be dangerous to my health. **

Print patient's name_____Patient's Birthdate: _____

Signature of Patient/Legal Guardian: _____Date: _____

Office Use Only:

Date	Changes Noted	Provider Initial	Patient/Guardian Signature	Date	Changes Noted	Provider Initial	Patient/Guardian Signature
_____	Yes or No	_____	_____	_____	Yes or No	_____	_____
_____	Yes or No	_____	_____	_____	Yes or No	_____	_____