Medical /Dental History

Your Physician/Clinic: _____ Phone#: ( ) _____-_____

Have you ever had the following

Y	N	Abnormal Bleeding	Y	N	Fainting	Y	N	Sinus Problems
Y	N	Alcohol/ Drug Abuse	Y	N	Headaches	Y	N	Stroke
Y	N	Anemia	Y	N	Glaucoma	Y	N	Thyroid Problems (Hypo or Hyper)
Y	N	Arthritis	Y	N	Hay Fever	Y	N	Tobacco Use
Y	N	Artificial Joints/Valves	Y	N	Heart Attack	Y	N	Tuberculosis
Y	N	Asthma	Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Blood Transfusion	Y	N	Heart Surgery	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Hemophilia	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Hepatitis (Type _____)	Y	N	Pacemaker
Y	N	Congenital Heart Failure	Y	N	Herpes/Fever	Y	N	Mental Health Diagnosis
Y	N	Diabetes	Y	N	High Blood Pressure	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	HIV + AIDS	Y	N	Rheumatic/ Scarlet Fever
Y	N	Emphysema	Y	N	Kidney Problems	Y	N	Shingles
Y	N	Epilepsy/Seizures	Y	N	Liver Disease	Y	N	Sickle Cell Disease
Y	N	Venereal Disease	Y	N	Currently Pregnant	Y	N	Obstructive Sleep Apnea
Y	N	Fibromyalgia	Y	N	Snore/Gasp During Sleep	Y	N	Experience Daytime Sleepiness

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Latex
Y	N	Codeine	Y	N	Erythromycin	Y	N	Metals
Y	N	Penicillin	Y	N	Tetracycline	Other: _____		

Please list all medications you are currently taking:

_____

_____

Have you ever taken Oral or IV Bisphosphirates or Osteoporosis (Fosamax, Boniva, etc) _____

Dental History

Reason for today's Visit:_____

Previous Dentist:_____ Last Dental Visit: _____

How often do you brush: _____ How often do you floss: _____

Please indicate if you have had the following:

Y	N	Bad Breath	Y	N	Bleeding Gums	Y	N	Blisters on mouth/lips
Y	N	Burning Sensation	Y	N	Chew on one side of mouth	Y	N	Cigarette, Pipe, or Cigar
Y	N	Clicking or Jaw Popping	Y	N	Dry Mouth	Y	N	Sensitive Teeth (hot/cold)
Y	N	Temporal Mandibular Disorder						

Signature:_____ **Date:**_____