Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please tell us the reason for your visit today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe:
_____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/_____/_____
Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?
_____

Have you ever had surgery? Yes No
If yes, when and what for? Date of surgery:_____ Reason for surgery:_____
Date of surgery:_____ Reason for surgery:_____

PATIENT MEDICAL HISTORY Do you have or have you ever had:					
Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants or artificial joints placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No

Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy? Yes No
Describe: _____Date of your last treatment? _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

FAMILY MEDICAL HISTORY
Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship _____	Cancer? Yes No Relationship _____
Heart disease? Yes No Relationship _____	Bleeding problems? Yes No Relationship _____
Tumors? Yes No Relationship _____ Sleep Apnea? Yes No Relationship _____	Lung disease? Yes No Relationship _____

FEMALE PATIENTS
Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS **Are you using any of the following:**					
Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No

Antianxiety agents, antidepressants or other psychiatric medications? Birth Control?	Yes Yes	No No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. _____ _____ _____ _____ _____ _____	Yes	No

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	**Dosage**	**Medication**	**Dosage**

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes No	Codeine or other pain killers?	Yes No
Food products?	Yes No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes No
Sedatives, barbiturates?	Yes No	Penicillin or other antibiotics?	Yes No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug or food allergies not listed above:

_____

SOCIAL HISTORY

Have you ever smoked ,vaped or chewed tobacco? Yes No	If yes, for how long? _____
Have you ever sought professional care or been hospitalized for:	**Do you use:**
Substance abuse? Yes No	Alcohol? Yes No How often? _____

Emotional disorders? Yes No Alcoholism? Yes No	Marijuana? Yes No How often? _____ Recreational drugs? Yes No How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?
_____
_____
____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____
Signature of patient, parent, guardian

_____
Printed name of patient, parent, guardian/Relationship

How did you hear about us?_____