PATIENT MEDICAL & DENTAL HISTORY

Date:_____

Name:_____ Birthdate:_____
Last First Middle

Address:_____
Street City State Zip

Patient Medical History

Physician:_____ Office Telephone: _____

Approximate date of last physical examination:_____

	Yes	No	
1. Are you under any medical treatment now?	____	____	_____
2. Have you ever had a serious accident involving head injuries?	____	____	_____
3. Have you ever had an adverse response to any drugs including penicillin?	____	____	_____
4. Has a physician ever informed you that you had:			
A heart ailment?	____	____	_____
Diabetes?	____	____	_____
Rheumatic fever?	____	____	_____
Rheumatism or arthritis?	____	____	_____
Any blood disease?	____	____	_____
Yellow Jaundice or Hepatitis?	____	____	_____
Epilepsy (seizures)?	____	____	_____
HIV (AIDS)?	____	____	_____
5. Are you taking drugs or medications?	____	____	_____
6. Are you allergic to any known materials resulting in hives, asthma, eczema?	____	____	_____
7. Have any wounds healed slowly or presented other complications?	____	____	_____
8. Are you in good health at this time?	____	____	_____

Patient Dental History

1. Do you have pain in or near your ears?	____	____	_____
2. Do you hear "clicks" or "pops" when opening your mouth?	____	____	_____
3. Do you find yourself clenching your teeth together often?	____	____	_____
4. Are your jaw muscles frequently sore in the morning?	____	____	_____
5. Does it hurt to open your mouth wide?	____	____	_____
6. Do your gums bleed easily when you brush your teeth?	____	____	_____
7. Do you at present have any dental complaints?	____	____	_____
8. When was your last full mouth X-ray taken?	____	____	_____
9. When was your last dental check-up?	____	____	_____

Signed _____