Medical History Notes, Current Medications, Consults
(office use only)

Date	

MEDICAL HISTORY

Patient's Physician: _____

Dr.'s City/Phone: _____

How is your general health? _____

Do you or have you ever had?

	YES	NO		YES	NO
1) Rheumatic Fever	[ ]	[ ]	10) Bleeding problem	[ ]	[ ]
2) Heart murmur	[ ]	[ ]	11) Epilepsy	[ ]	[ ]
3) Hepatitis	[ ]	[ ]	12) Sexually transmitted disease	[ ]	[ ]
4) Diabetes	[ ]	[ ]	13) Artificial joint(s) or valve(s)	[ ]	[ ]
5) Heart condition	[ ]	[ ]	14) Pacemaker	[ ]	[ ]
6) Frequent Headaches	[ ]	[ ]	15) Psychiatric problem	[ ]	[ ]
7) Digestive problems	[ ]	[ ]	16) Infectious disease or H.I.V.	[ ]	[ ]
8) Asthma	[ ]	[ ]	17) Cancer or Leukemia	[ ]	[ ]
9) Radiation treatment	[ ]	[ ]	18) Ever Taken Medicine(s) for Osteoporosis	[ ]	[ ]

17) Any medical condition? _____

18) Blood pressure is (Low) (Normal) (High) (Don't know)

19) Allergic to? (Penicillin) (Codeine) (Novocaine) (Other): _____

20) Recent operations or hospitalizations? _____

21) What medications, vitamins or homeopathic substances, if *any* are you taking?

22) How much do you use:

Coffee/Tea _____ Cigarettes, pipe or cigars _____

Smokeless Tobacco _____ Alcoholic beverages _____

23) Are you pregnant? (No) (Yes) - > How many weeks? _____ Due date _____

24) Are you taking oral contraceptives "the pill"? _____

DENTAL HISTORY

25) Reason for this visit? _____

26) Last dental exam? _____

27) Do you avoid any part of your mouth due to sensitivity? _____

28) Do any teeth hurt? _____ (now) (cold) (hot) (sweets) (chewing) (change of position) (brushing)

Do you or have you ever had?

	YES	NO		YES	NO
29) Gum disease	[ ]	[ ]	32) Clicking or pain on opening	[ ]	[ ]
30) Bleeding or tender gums	[ ]	[ ]	33) Facial pain or earache	[ ]	[ ]
31) A sinus condition	[ ]	[ ]	34) Clenching or grinding teeth	[ ]	[ ]

35) A removable denture (bridge)? _____ How old? _____

36) Do you like your smile (how it looks)? _____

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Please hand this to the receptionist when you have finished both sides. Thank you.