Patient Name _____

Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now? If yes, please explain _____ _____	☐	☐
2. Have you ever been hospitalized for any surgical or serious illness within the last 5 years? If yes, please explain _____ _____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? Please list: _____ _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you allergic to any medications? If so, what:_____ _____	☐	☐
7. Have you ever had any problems with dental anesthetic?	☐	☐
8. Are you under treatment for **Osteoporosis?** Please list medications: _____	☐	☐
9. Have you ever taken bisphosphonate medications such as: Fosamax, Boniva, Actonel, Reclast?	☐	☐

10. CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE OR NOW HAVE:

High/Low blood pressure	Heart Attack
*Rheumatic Fever	Asthma
AIDS	Thyroid problems
Heart Disease	Pacemaker
*Heart murmur	Anemia
Emphysema	Cancer
Arthritis	Liver disease
Heart trouble	*Mitral Valve Prolapse
Diabetes	Hepatitis
Artificial Heart Valve	Oral Herpes/Cold Sores
Shortness of breath	TMJ
Venereal Disease	Stroke
Sleep Apnea	
*Hip, Knee or Joint replacement/implants	
Pain in chest, neck, arm or jaw on exertion	
Other _____	

11. **Do you need to Pre-Med with antibiotics for any of the above * conditions? _____**

Dental History

Date of Last Exam _____ Date of Last Full Series of X-Rays _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot/cold?	☐	☐
3. Do you feel pain in any of your teeth?	☐	☐
4. Do you have any sores or bumps in your mouth?	☐	☐
5. Do you have areas of concern today?	☐	☐
6. Are you interested in whitening your teeth?	☐	☐

7. CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOU:

Clicking of jaw joints	Loose teeth
Pain (jaw, ears or side of face)	Dizziness
Difficulty in opening or closing	Difficulty in swallowing
Frequent headaches	Snoring
Clenching or grinding of teeth	Excessive tiredness

Signature _____ Date _____

ANNUAL UPDATES: If nothing has changed, please initial & date line below

_____ _____ _____ _____ _____